Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin
Department of Health and Family Services

DIVISION OF HEALTH

1 WEST WILSON STREET
P. O. BOX 309
MADISON WI 53701-0309

MEMORANDUM

DATE: January 14, 1997

TO: Physical Therapists
Outpatient Hospitals
Therapy Clinics
Rehabilitation Agencies

FROM: Peggy L. Bartels, Director PLB for
Bureau of Health Care Financing

SUBJECT: Wisconsin Medicaid Provider Handbook, Part P, Division II

Enclosed is the first issue of the Wisconsin Medicaid provider handbook, Part P, Division II, for physical therapy services.

The Wisconsin Physical Therapy Association's Medicaid subcommittee was instrumental in the development of this handbook.

This handbook:

- Compiles in one place the current policies and information from earlier Medicaid provider publications (bulletins, updates and handbook).

- Clarifies Wisconsin Medicaid's existing policies, requirements and limitations for prior authorization and spell of illness; provider certification types for physical therapy; coverage and reimbursement of school-based services (SBS), and the impact of this benefit on non-school Medicaid physical therapists; and communication with other Medicaid providers (including SBS and others).

You will find this handbook helpful in submitting and amending your prior authorization requests, getting your claims paid quickly and efficiently, and in resolving any billing problems you encounter. Please keep the most recent update regarding HCPCS and CPT procedure codes until you receive handbook replacement pages. We will communicate future policy changes through Wisconsin Medicaid Updates and handbook replacement pages.

We appreciate your interest in providing services to Medicaid recipients. Thank you for becoming a Medicaid provider.

PLB:vg
CH09073.CW

Enclosure

Introduction

Read all materials before initiating services to ensure a thorough understanding of Medicaid policy and billing procedures.

Wisconsin Medicaid is governed by the Wisconsin Administrative Code, Rules of Health and Family Services, Chapters HSS 101-108, and by state and federal law. Two parts of the Wisconsin Medicaid provider handbook interpret these regulations. The two parts of the handbook are designed for use with each other and with the Wis. Admin. Code.

Part A, the all-provider handbook, includes general policy guidelines, regulations, and billing information applicable to all types of certified providers. *Part P, Division II,* the service-specific part of the handbook, includes information on provider eligibility criteria, covered services, payment methodology, prior authorization, and billing instructions. The Wisconsin Medicaid Managed Care Guide's provider section includes information on policy guidelines and regulations for AFDC/Healthy Start recipients and the managed care program. Each provider is sent a copy of Part A, the all-provider handbook, the appropriate service-specific handbook, and the Wisconsin Medicaid Managed Care Guide's provider section at the time of certification.

Purchase additional copies of provider handbooks by completing the order form in Appendix 36 of Part A, the all-provider handbook.

When requesting a handbook, be sure to indicate the service provided (e.g., physician, chiropractic, dental). For a complete source of Medicaid regulations and policies, refer to HSS 101-108, Wis. Admin. Code. If there is any substantive conflict between HSS 101-108 and the handbook, the meaning of the Wis. Admin. Code holds. Providers may purchase HSS 101-108 from Document Sales at the address in Appendix 3 of Part A, the all-provider handbook.

There are other documents, including state and federal laws and regulations, relating to Wisconsin Medicaid:

- Sections 49.43 - 49.497, Wisconsin Statutes.
- Title XIX of the Social Security Act and its enabling regulations, Title 42 - Public Health, Parts 430-456.

A list of common terms and their abbreviations is in Appendix 30 of Part A, the all-provider handbook, and in HSS 101, Wis. Admin. Code.

Physical Therapy
Table of Contents

A. Type of Handbook

Part P, Division II, is the service-specific portion of the Wisconsin Medicaid provider handbook. Part P, Division II, includes information about provider eligibility criteria, recipient eligibility criteria, covered services, payment rates, prior authorization, and billing instructions. Use Part P, Division II, with Part A, the all-provider handbook, which includes general policy guidelines, regulations, and billing information applicable to all types of certified providers. Refer to the Wisconsin Medicaid Managed Care Guide's provider section for general policy and regulation information for AFDC/Healthy Start recipients and the managed care program.

B. Provider Information

Provider Eligibility and Certification

General information on Medicaid certification requirements is in Section II of Part A, the all-provider handbook.

Certification Requirements for Physical Therapists (PTs)

For Medicaid certification:

- ✓ PTs must be licensed under ss. 448.05 and 448.07, Wis. Stats., and Med 7, Wis. Admin. Code.
- ✓ PTs who are granted border-status are exempt from the Wisconsin licensure requirement but must be licensed by the appropriate agency in the state in which they practice.
- ✓ PTs with temporary licenses or registrations are eligible for temporary certification. This certification is canceled effective 60 days after the next oral examination is given unless the provider submits proof of a permanent license to Wisconsin Medicaid before that date.

All PTs (other than PTs providing services *exclusively* for a rehabilitation agency, home health agency, school-based services [SBS] provider, or *at a licensed hospital location*) must be individually certified.

Certification Requirements for Physical Therapy Assistants (PTAs)

For Medicaid certification, PTAs must meet and do all of the following:

- ✓ Graduate from a two-year college-level program approved by the American Physical Therapy Association.
- ✓ Provide services under the direct, immediate, onsite supervision of a Medicaid-certified PT.
- ✓ Submit a copy of the PTA transcript.
- ✓ Submit the "Wisconsin Medicaid Declaration of Supervision for Non-Billing Providers."

All PTAs (other than PTAs providing services *exclusively* for a rehabilitation agency, home health agency, SBS provider, or *at a licensed hospital location*) must be individually certified. PTAs cannot be independent providers due to Medicaid supervision requirements. The provider number issued to a PTA is used *only* as the performing provider number on all submitted claims and may *not* be used as a billing provider number.

Note: Claims for services (other than rehabilitation agency, SBS, or *at* a hospital) must be billed with a group billing number or the certified PTA supervisor's provider number. The PTA's non-billing performing provider number must be included as the performer.

B. Provider Information (continued)

Change in Supervision, Employment, or Address for Certified PTAs
When a certified PTA has a change in his/her PT supervisor, the PTA must complete a new "Wisconsin Medicaid Declaration of Supervision for Non-Billing Providers" form. Refer to Appendix 15 of this handbook (or Appendix 34 of Part A, the all-provider handbook) for the supervision form. When a certified PTA also has a change in address or employment, the PTA must complete the "Wisconsin Medicaid Provider Change of Address or Status" form. Refer to Appendix 34 of Part A, the all-provider handbook, for the change of address and status forms. Please photocopy these forms as needed.

Therapists Certified by the Department of Public Instruction (DPI)
Therapists certified by the DPI who do not meet Medicaid's certification requirements are not eligible for individual Medicaid certification. Their services are billable only by SBS providers.

Physical Therapy Aides
Physical therapy aides are not separately certified by Wisconsin Medicaid. Refer to Section II of this handbook for information on physical therapy aide services and limitations.

Certification Requirements for Rehabilitation Agencies
Rehabilitation agencies must meet the criteria in HSS 105.34, Wis. Admin. Code: "For Medicaid certification, a rehabilitation agency providing outpatient physical therapy, or speech and language pathology, or occupational therapy will be certified to participate in *Medicare* as an outpatient rehabilitation agency under 42 CFR 405.1702 to 405.1726."

A rehabilitation agency does all of the following:

- ✓ Provides an integrated multi-disciplinary program of services to upgrade the physical functioning of handicapped, disabled individuals.
- ✓ Brings together a team of specialized rehabilitation personnel to provide these services.
- ✓ Provides services which, at a minimum, consist of physical therapy, speech pathology, rehabilitation program, social, or vocational adjustment services.

Rehabilitation agencies must meet a number of requirements which do not apply to independent therapists. The following is a general description of *Medicare* certification requirements for rehabilitation agencies which providers must meet before receiving Medicaid certification:

- ✓ Have a governing body and a full-time administrator.
- ✓ Have written personnel policies and written recipient care policies.
- ✓ Have a physician available to furnish emergency medical care.
- ✓ Provide social or vocational adjustment services to all recipients in need of such services by making available psychologists, social workers, or vocational specialists (either as salaried employees or on contract).
- ✓ Have certain safety features, such as a fire extinguisher, readily negotiable stairways, and lighting and fire alarm systems (a minimum of two people must be on duty at all times).
- ✓ Meet federal requirements concerning lighting, ventilation, lavatories, and general space regardless of whether these are required by state or local licensure laws.

B. Provider Information (continued)

- ✓ Have an infection-control committee.
- ✓ Have a full-time employee responsible for house-keeping services or must contract for such services.
- ✓ Have a pest-control program.
- ✓ Provide staff training and drills on disaster preparedness.
- ✓ Provide for quarterly review and evaluation of a sample of clinical records by appropriate health professionals.
- ✓ Conduct an annual statistical evaluation of its services.

PTs employed by, or under contract to, rehabilitation agencies are not required to be individually certified by Wisconsin Medicaid (unless they have private patients for whom they bill independently). However, PTs and PTAs employed by, or under contract to, rehabilitation agencies must meet all of the requirements for Medicaid certification. The rehabilitation agency must maintain records showing that they meet these requirements.

Medicaid Certification Process for Rehabilitation Agencies

Providers must apply simultaneously to Medicare and Wisconsin Medicaid for certification as a rehabilitation agency to ensure the effective certification dates coincide. Wisconsin Medicaid must verify the Medicare certification number before a Medicaid provider number is issued. Medicaid therapy group providers considering conversion to the Medicaid rehabilitation agency provider type may contact the fiscal agent. Contact the fiscal agent to obtain the application, obtain more information about the detailed conversion process, and to ensure services are billed appropriately during the conversion process. Refer to Appendix 2 of Part A, the all-provider handbook, for the fiscal agent's Provider Maintenance mailing address and Correspondence Unit telephone numbers.

Before receiving Medicare certification, a rehabilitation agency is surveyed by the Wisconsin Department of Health and Family Services (DHFS) under a contract with the federal Health Care Financing Administration (HCFA). The survey reviews the agency's administration and rehabilitation programs.

Certification for Durable Medical Equipment (DME)

Certified PTs and rehabilitation agencies do not need separate certification as a DME provider to provide the equipment identified in the DME Index as billable by physical therapy providers, or by those therapy groups, clinics, and rehabilitation agencies which include physical therapy. Separate DME certification is required to provide DME that are not identified as billable by these therapy provider types.

All DME policy and billing instructions for certified therapy and DME providers are in the DME and Disposable Medical Supplies (DMS) provider handbook, Part N. All therapy providers receive a copy of Part N. If you want additional copies, request the Part N provider handbook by writing to:

EDS
Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

B. Provider Information (continued)

Types of Medicaid Provider Numbers Issued to Individuals and Organizations Providing PT Services

Individual Performing Provider, Billing

The following applies for a PT who can practice independently:

- ✓ The PT can independently provide services, bill Wisconsin Medicaid directly, and request prior authorization (PA) for the PT's services provided to Medicaid recipients.
- ✓ The PT can bill and request PA for the services of assistants the PT supervises.
- ✓ The PT's Medicaid provider number may be used as a billing number or a performing number.

The individual PTs included are the following:

- ✓ PTs in independent practice.
- ✓ PTs working under contract/arrangements with a nursing home where the PT acts as an individual performing provider (the nursing home's provider number must be used to bill Wisconsin Medicaid and request PA if the claims are to be paid to the nursing home).
- ✓ PTs working for an organization that is required to indicate the performer's number on the claim (the PT's number is used as the performing provider number if a group billing number is used [see next section]).

Individual Performing Provider, Non-Billing

The following applies for an PTA working under the immediate onsite supervision of a Medicaid-certified PT:

- ✓ The PT allows the PTA to provide services to Medicaid recipients. Those services are then billed to Wisconsin Medicaid using the provider number of the PTA's supervisor or clinic along with the PTA's number as the performing provider number.
- ✓ The PTA's Medicaid provider number can be used as a performing number, *not* as a billing number.

The individual PTAs included are the following:

- ✓ PTAs supervised by a Medicaid-certified PT in independent practice.
- ✓ PTAs supervised by a Medicaid-certified PT in an organization required to include the performing provider's number on the claim.

Group Billing Number, Performing Provider Number Is Required

A group billing number is issued as an accounting or billing convenience for groups of individually certified providers. The group billing number allows the group of individuals to do all of the following:

- ✓ Bill Wisconsin Medicaid.
- ✓ Receive one payment for each claims processing cycle.
- ✓ Request PA under the group billing number.

B. Provider Information (continued)

Examples of groups with individually certified providers include the following:

- ✓ *Therapy groups* - Provide two or more types of therapy (e.g., PT and OT or PT, OT, and Speech).
- ✓ *Therapy clinics* - Provide one type of therapy only (e.g., PT or OT).
- ✓ *Nursing home* - PT provided by PT staff employed by, or under contract with, the nursing home; the nursing home's provider number is used as the billing number.
- ✓ *Licensed hospital's off-site services* - Hospital PT staff providing PT services off the licensed hospital site (services cannot be billed as hospital outpatient; they must be billed fee-for-service and include the performing provider number).

Group Billing Number, Performing Provider Number Is Not Required

The following applies for some organizations employing PT staff who meet the Medicaid individual certification requirements (exclude school-based services [SBS] provider's staff) and does not require a performing provider number:

- ✓ The organization may bill Wisconsin Medicaid, receive one payment for each claims processing cycle, and request PA under one provider number.
- ✓ No separate Medicaid certification is required for individual performing providers. However, the Medicaid-certified organization must maintain records documenting that their PTs and PTAs meet Medicaid certification requirements for PTs and PTAs (excludes SBS providers).

Examples of organizations employing PT staff who are not required to obtain a separate Medicaid performing provider number include the following:

- ✓ Rehabilitation agencies.
- ✓ Licensed hospitals (only for services provided at the licensed hospital site; individual certification of staff is required for services provided off the licensed hospital site and claims require the performer's provider number).
- ✓ Home health agencies with PTs providing therapy services.
- ✓ School districts and Cooperative Educational Service Agencies (CESAs) certified as SBS providers; therapy services provided at school must be billed with an SBS provider number. SBS staff must meet DPI certification and licensure requirements, not Medicaid certification requirements.

Scope of Service

The policies in Part P, Division II, govern services provided within the scope of the profession's practice as defined in Section 448.01 (4), Wis. Stats, N 12, Wis. Admin. Code, and HSS 107.16, Wis. Admin. Code. Refer to Section II of this handbook for covered services and related limitations.

Payment Methods

Physical therapy and rehabilitation agency services are paid the lesser of the following:

- ✓ The provider's usual and customary charge.
- ✓ The maximum allowable fee.

B. Provider Information (continued)

The Medicaid maximum allowable fee applies to one treatment unit, which coincides with the specific Current Procedural Terminology (CPT) and HCFA Common Procedure Coding System (HCPCS) procedure code descriptions. (Refer to Section IV of this handbook for information about Medicaid procedure codes.) Payment for treatment less than the procedure code unit per session is prorated. Additional units are paid only when a full unit of service is actually provided. Refer to Appendix 4 of this handbook for specific procedure codes and treatment units.

Facility Overhead Costs

Payment for direct and associated overhead costs is included in the payment for each treatment unit.

Provider Responsibilities

Specific responsibilities as a certified provider are stated in Section IV of Part A, the all-provider handbook. Refer to Section IV of Part A, the all-provider handbook, for information about the following:

- ✓ Fair treatment of the recipient.
- ✓ Maintenance of records.
- ✓ Recipient requests for noncovered services.
- ✓ Services rendered to a recipient during periods of retroactive eligibility.
- ✓ Grounds for provider sanctions.
- ✓ Additional state and federal requirements.

C. Recipient Information

Verifying Recipient Eligibility

Eligible recipients receive identification cards monthly that are valid through the end of the month issued. The identification cards include the recipient's name, date of birth, 10-digit identification number, medical status code, and, when applicable, an indicator of health insurance, HMO, and Medicare coverage.

Note: Check the recipient's identification card *before* providing service to determine recipient eligibility and any limitations to their coverage.

Section V of Part A, the all-provider handbook, provides detailed information about Medicaid eligibility, identification cards, temporary cards, restricted cards, and eligibility verification. *Review* Section V of Part A, the all-provider handbook, *before* rendering services. A sample identification card is in Appendix 7 of Part A, the all-provider handbook.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining physical therapy services. Refer to Appendix 4 of this handbook for procedure codes and their applicable copayment amounts.

Copayment exemptions include the following:

- ✓ Emergency services.
- ✓ Services provided to nursing home residents.
- ✓ Services provided to recipients under 18 years of age.
- ✓ Services provided to a pregnant woman if the services are pregnancy-related.

C. Recipient Information (continued)

- ✓ Services covered by Medicaid-contracted managed care programs to enrollees of the managed care program.
- ✓ Family planning services and related supplies.

Providers must make a reasonable attempt to collect copayment from the recipient. Providers are not allowed, at their discretion, to waive the recipient copayment requirement. The provider cannot deny a service to a recipient who fails to make a copayment.

The fiscal agent automatically deducts applicable copayment amounts from payments allowed by Wisconsin Medicaid. Do not reduce the billed amount of the claim by the amount of recipient copayment.

No copayment is deducted after the first 30 hours or $1,500 of services per calendar year.

Recipients Enrolled in Managed Care Programs

Recipients enrolled in Medicaid-contracted managed care programs (including Medicaid Health Maintenance Organization, or HMOs) receive a yellow identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. Refer to Chapter 4 in the Wisconsin Medicaid Managed Care Guide's provider section for the HMO Medicaid ID codes.

Providers must check the recipient's current identification card for managed care program coverage before providing services. Wisconsin Medicaid denies claims submitted to the fiscal agent for services covered by Medicaid-contracted managed care programs. Physical therapy claims must be submitted to the managed care program.

For recipients enrolled in a Medicaid-contracted managed care program, the contract between the managed care program and certified provider establishes all conditions of payment and prior authorization for physical therapy services.

Managed care programs exclude physical, occupational, and speech therapy provided in the school from coverage under their program. Refer to Appendix 22 of Part A, the all-provider handbook, for more information.

Refer to Wisconsin Medicaid Managed Care Guide's provider section for additional information about managed care program noncovered services, emergency, services, and hospitalizations.

D. HealthCheck

HealthCheck is Medicaid's federally mandated program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). HealthCheck consists of a comprehensive screening of eligible recipients under the age of 21, which includes the following:

- ✓ Review of growth and development.
- ✓ Identification of potential physical or developmental problems.
- ✓ Preventive health education.
- ✓ Referral assistance to appropriate providers of service.

HealthCheck also includes targeted outreach and case management services to "at risk" children to ensure that these children have access to needed medical, social, and educational services.

D. HealthCheck (continued)

Note: Wisconsin Medicaid covers medically necessary physical therapy services under the physical therapy benefit. HealthCheck benefit services also must be medically necessary. A request for prior authorization of physical therapy services that is denied for lack of medical necessity under the physical therapy benefit generally is not approved under the HealthCheck benefit because both benefits use medical necessity as the same prior authorization criteria and requirement.

Wisconsin Medicaid considers requests for medically necessary physical therapy services (under the HealthCheck benefit) which are not specifically listed as covered services when all of the following conditions are met:

- ✓ The service requested is for an individual under 21 years of age.
- ✓ The service is medically necessary to correct or improve a condition or defect discovered during a HealthCheck/EPSDT screening.
- ✓ The service is one which is an allowable service under federal regulations.

All such services require prior authorization for payment. Refer to Section III of this handbook for prior authorization information.

Refer to Section IV of Part A, the all-provider handbook, for additional information on HealthCheck "Other Services."

E. School-Based Services (SBS) Benefit

Background

Provisions of 1995 Wisconsin Act 27, the biennial budget, established a School-Based Services (SBS) benefit. The benefit allows schools and cooperative educational services agencies (CESAs) to bill Wisconsin Medicaid for medically necessary services provided to Medicaid-eligible children under age 21 or for any school term during which the individual became 21 years old. This benefit became effective for dates of service on and after July 1, 1995.

Covered SBS Services

The following services are covered under the SBS benefit when they are identified in the child's Individualized Education Program (IEP) or Individualized Family Service Program (IFSP) and certain requirements are met:

1. Physical therapy.
2. Occupational therapy.
3. Speech, language, audiology, and hearing.
4. Nursing.
5. Psychological services, counseling, and social work.
6. Developmental testing and assessments when they result in an IEP/IFSP;
7. Transportation.
8. Durable medical equipment (DME) not covered under Medicaid's DME benefit.

E. School-Based Services Benefit (continued)

Certification for School-Based Services: Impact on Therapy Providers

Effective July 1, 1996, all services covered under the SBS benefit that are delivered at a school site must be billed under the school district's or CESA's SBS provider number. This includes services delivered by school and non-school employees (or CESA and non-CESA employees) who are under contract or arrangement with the school district or CESA to deliver services at the school site.

Services under the SBS benefit that are delivered at a school site may not be billed by individuals or groups with the following Medicaid certification that duplicates SBS certification:

- ✓ Physical therapy and therapy assistants.
- ✓ Rehabilitation agency.
- ✓ Therapy groups.
- ✓ Occupational therapy and therapy assistants.
- ✓ Speech and hearing clinics.
- ✓ Audiologists.
- ✓ Speech pathology/therapy.
- ✓ Transportation.
- ✓ Nurse practitioners.

Effective July 1, 1996, individual providers cannot be certified for the above duplicate service areas when a school, school district, or CESA is the provider's payee. School districts and CESAs are not eligible for new group certification for the above provider groups on and after July 1, 1996.

A. Introduction

As specified in HSS 107.16, Wis. Admin. Code, covered physical therapy services are defined as medically necessary evaluations, modalities, and procedures prescribed by a physician. Refer to HSS 101.03 (96m), Wis. Admin. Code, for the definition of "medically necessary." The services must be performed by one of the following:

- ✓ Certified PT.
- ✓ Certified physical therapy assistant (PTA) under the direct (on premise) supervision of a PT.
- ✓ Physical therapy aide for specific services and when specific supervisory requirements are met (refer to Section II-E of this handbook for more information).

Services that do not require the skills of a PT (e.g., nursing services, active treatment services, activity services, and caregiver services) are not covered.

B. Covered Services

Evaluations

An *evaluation* consists of one or more tests or measures used to assess a recipient's needs. Evaluations are not paid when provided by a PTA or physical therapy aide. Refer to Appendix 6 of this handbook for a listing of types of covered evaluation services.

Evaluation days are, from a prior authorization threshold standpoint, considered treatment days and are counted toward the 35 treatment days within a spell of illness.

Therapy Evaluations in Facilities for the Developmentally Disabled

In most situations, a full professional evaluation by a therapy professional is *not* required annually for residents in a Facility for the Developmentally Disabled (FDD). Federal regulations require that the comprehensive assessment is reviewed at least annually for each resident in a FDD or Intermediate Care Facility for the Mentally Retarded (ICF-MR). Federal regulations [Interpretive Guidelines - Intermediate Care Facilities for the Mentally Retarded; Health Care Financing Administration Federal Regulations: State Operations Manual 212 483.440 (c) (3) (v)] require the facility to assess developmental *areas*, but *not* by professional disciplines unless the functional assessment shows a need for a full professional evaluation.

A physical therapy evaluation by a therapy professional must specify the recipient's current level of functioning and include one of the following:

- ✓ Specific recommendations for a therapy program, including measurable treatment goals.
- ✓ Specific current recommendations for active treatment, including specific instructions for other treatment staff.

Therapy evaluations in FDDs are subject to the spell of illness (SOI), prior authorization, daily duration, and other limitations referred to under HSS 107.16, Wis. Admin. Code. This applies to comprehensive therapy evaluations by independent and rehabilitation agency providers.

Modality

A *modality* consists of a treatment involving physical therapy equipment or apparatus which does not require the PT's personal continuous attendance when in use, but does require setting up, frequent observations, and evaluation of the treated body part before and after treatment. Refer to Appendix 7 of this handbook for a list of modalities.

B. Covered Services (continued)

Procedure

A *procedure* consists of a treatment (with or without equipment or apparatus) which requires the PT's personal continuous attendance. Refer to Appendix 8 of this handbook for a list of covered procedures.

Electrical Stimulation

Electrical stimulation for pressure sore treatment is covered only for stages III and IV pressure sores. Services must be performed under a PT's direct supervision.

C. Plan of Care

As specified in HSS 107.16, Wis. Admin. Code, a physician must prescribe (sign and date) or co-sign orders for physical therapy services for Medicaid coverage of the service. Therapists may document a physician's verbal order and then obtain the physician's signature and date.

A plan of care must be established and reduced to written form. As specified in HSS 107.16 (3) (a) 2, Wis. Admin. Code, the physician must review the plan of care in consultation with the provider. Reviews must occur at intervals required by the severity of the recipient's condition, but at least every 90 days. The plan of care may become the prescription when signed and dated by the physician. The provider must retain the plan of care in the recipient's permanent record.

The plan of care must include all of the following:

- ✓ The type, amount, frequency, and duration of the therapy services.
- ✓ All evaluations or results of current status reports that justify the plan of care.
- ✓ The diagnosis, a functional evaluation, and anticipated goals.

Changes to the plan, per the attending physician's verbal orders, must be in writing and signed and dated by the physician and the therapy provider.

D. Daily Service Limitations

Ninety-Minute Daily Coverage Limitations

As specified in HSS 101.03 (96m) and HSS 107.02 (2) (b), Wis. Admin. Code, Wisconsin Medicaid does not cover physical therapy services beyond 90 minutes per day unless coverage of additional medically necessary treatment is requested and approved through the claims adjustment process (see next paragraph). This limit is based on the determination that physical therapy services in excess of 90 minutes per day generally exceeds the medically necessary, reasonable, and appropriate duration of physical therapy services.

If, under extraordinary circumstances, physical therapy treatment is necessary beyond the limitation of 90 minutes per day, coverage of additional treatment time may be requested by submitting an adjustment request form after the claim is paid. The specific medical reason for exceeding the 90-minute limitation must be documented on the adjustment request form. Refer to Section X and Appendices 27 and 27a of Part A, the all-provider handbook, for information on submitting an adjustment request.

Daily Unit of Service Limitation

Wisconsin Medicaid covers some procedure codes only a limited number of times a day. Refer to 'Daily Unit of Service Limit' in Appendix 4 of this handbook for specific limits.

E. Allowed Procedures for PTAs

PTAs may not perform some Medicaid procedures such as evaluations. Refer to Appendix 4 for the procedure codes PTAs may perform.

F. Physical Therapy Aide Services

As specified in HSS 107.16 (1) (e), Wis. Admin. Code, physical therapy aides must be trained in a manner appropriate to their job duties. Clinical services that exceed a physical therapy aide's competence, education, training, and experience are not payable. Physical therapy aide services must be provided under the direct, immediate, on-premise supervision of a PT. The PT-to-physical therapy aide ratio must be 1:1 for billable services, except as noted in the next two paragraphs.

As specified in HSS 107.16 (1) (e), Wis. Admin. Code, the Department of Health and Family Services (DHFS) may exempt a facility providing physical therapy services from the supervision requirement if it determines that direct, immediate, one-to-one supervision is not required for specific assignments which physical therapy aides are performing at that facility.

For example, facilities providing significant amounts of hydrotherapy may be eligible for an exemption for physical therapy aides who fill or clean tubs. If an exemption is granted, the DHFS indicates the specific physical therapy aide services for which the exemption is granted and sets a supervision ratio appropriate for those services. Refer to HSS 106.13, Wis. Admin. Code, for more details on waiver requirements.

Physical therapy aides are not paid directly for their services.

As specified in HSS 107.16 (1) (e), Wis. Admin. Code, the following physical therapy aide services may be provided:

- ✓ Performing simple activities required to prepare a recipient for treatment, assisting in the performance of treatment, or assisting at the conclusion of treatment (such as helping the recipient to dress or undress, transferring a recipient to or from a mat, and applying or removing orthopedic devices).
- ✓ Assembling and disassembling equipment and accessories in preparation for treatment or after treatment has taken place.
- ✓ Assisting with the use of equipment and performing simple modalities once the recipient's program has been established and the recipient's response to the equipment is highly predictable.
- ✓ Providing protective assistance during exercise, activities of daily living, and ambulation activities related to the development of strength and refinement of activity.

G. Spell of Illness (SOI)

Definition

As specified in HSS 107.16 (1) (2) (a) through (e), Wis. Admin. Code, a "spell of illness" is a documented condition in which a recipient has a loss of functional ability to perform daily living skills. This loss of functional ability may be caused by a new disease, injury, medical condition, or by increased severity of a pre-existing medical condition.

Documenting an SOI

As specified in HSS 107.16 (2) (c), Wis. Admin. Code, the provider must document an SOI in the patient's plan of care, including all of the following:

- ✓ Measurable evidence that the recipient has incurred a demonstrated functional loss of ability to perform daily living skills.
- ✓ Has the potential to achieve his/her previous level of functional ability.

G. **Spell of Illness (SOI)** (continued)

When an SOI Begins

An SOI begins with the first day of treatment or evaluation following the onset of a new disease, injury, medical condition, or increased severity of a pre-existing medical condition.

The Recipient's First SOI

A recipient's first SOI is the first time the recipient requires therapy in their lifetime.

Treatment Days Allowed Within an SOI

Up to 35 treatment days are allowed per SOI. The 35 treatment days include all of the following:

- ✓ Evaluations.
- ✓ Treatment days covered by Medicare or health insurance.
- ✓ Treatment days provided by another provider, in any outpatient setting.

Unused treatment days from one SOI cannot be carried over into a new SOI. When a new authorized SOI occurs within the current SOI, the old (current) SOI stops, and a new SOI begins. The new authorized SOI has 35 treatment days. Prior authorization must be obtained for continued physical therapy services beyond the SOI.

When an SOI Ends

An SOI ends when the recipient's condition improves so that the services of a PT are no longer required or after 35 treatment days, whichever comes first.

Approval Process for an SOI

The recipient's first SOI in their lifetime does not need prior approval for payment of medically necessary services. After the first SOI, all additional SOIs require approval for payment by submitting a "Prior Authorization Spell of Illness Attachment" (PA/SOIA) and "Prior Authorization Request Form" (PA/RF) as soon as possible before billing for services.

Appendices 11 through 13 of this handbook contain instructions for submitting documentation for second and subsequent SOIs. The "Spell of Illness Guide" in Appendix 13 of this handbook further clarifies the SOI procedure.

Approval Criteria for a New SOI

As specified in HSS 107.16 (2) (a), (b), and (c), Wis. Admin. Code, to consider a condition as a new SOI, recipients must display the potential to reachieve the previously attained level of independence exhibited immediately before the onset of the SOI.

The following conditions may justify a new SOI:

- ✓ An acute onset of a new disease, injury, or condition such as one of the following:
  - → Neuromuscular dysfunction, including stroke-hemiparesis, multiple sclerosis, Parkinson's disease, and diabetic neuropathy.
  - → Musculoskeletal dysfunction, including fracture, amputation, strains and sprains, and complications associated with surgical procedures.
  - → Problems and complications associated with physiologic dysfunction, including severe pain, vascular conditions, and cardio-pulmonary conditions.

G. Spell of Illness (SOI) (continued)

- ✓ An exacerbation of a pre-existing condition, including but not limited to the following, which requires physical therapy intervention on an intensive basis such as one of the following:
  - → Multiple sclerosis.
  - → Rheumatoid arthritis.
  - → Parkinson's disease.
- ✓ A regression in the recipient's condition, due to a lack of physical therapy, as indicated by a decrease of functional ability, strength, mobility, or motion.

Services in Excess of 35 Treatment Days per SOI
Prior authorization is required for physical therapy services in excess of 35 treatment days for conditions that do not qualify for a new SOI.

H. Additional Requirements

Coverage of Treatment for Conditions That Never Qualify for an SOI
Certain conditions never qualify for an SOI such as decubitus ulcers and mental retardation.

For conditions that do not qualify for an SOI and for certain other procedures, prior authorization is required starting with the first day of treatment. Refer to Section III of this handbook for more information.

Co-Treatment (Interdisciplinary Treatment)
Co-treatment is covered only when medically necessary. Co-treatment is simultaneous treatment by two different therapy providers at the same time period, (e.g., by speech pathology and occupational therapy, or physical therapy and occupational therapy). Co-treatment may be requested when the unique treatment approach offered by multiple therapies during the same treatment session is medically necessary to optimize the recipient's rehabilitation. Refer to Section III of this handbook for more information.

Duplicate Services
As specified in HSS 101.03 (96m), Wis. Admin. Code, Wisconsin Medicaid does not cover duplicate services provided to recipients who have received physical therapy services from another certified provider. Before beginning evaluations or therapy, providers are advised to request prior authorization. For example, Wisconsin Medicaid may deny payment when another provider had a valid prior authorization for therapy services or when prior payment for physical therapy services has been received by another provider under a recipient's first or subsequent SOI.

Preventive/Maintenance Therapy Services
As specified in HSS 107.16 (3) (c), Wis. Admin. Code, Wisconsin Medicaid covers preventive/maintenance therapy services when one or more of the following conditions are met:

- ✓ The skills and training of a therapist are required to execute the entire preventive and maintenance program (e.g., there is no one else qualified to provide the level of care required).
- ✓ The specialized knowledge and judgment of a PT are required to establish and monitor the therapy program including the following:

H. Additional Requirements (continued)

- → The initial evaluation.
- → The design of the appropriate program.
- → The instruction of nursing personnel, family, caregiver, or recipient.
- → The required re-evaluations.

✓ The nursing personnel cannot handle the recipient safely and effectively due to the severity or complexity of the recipient's condition.

I. Durable Medical Equipment (DME) and Disposable Medical Supplies (DMS)

Durable medical equipment (DME) are medically necessary devices that can withstand repeated use. DME primarily serve a medical purpose and are generally not useful to a person without an illness or injury. All items must be appropriate for use in the recipient's place of residence.

DME are covered only when prescribed by a physician and listed as covered services in the Wisconsin DME Index for therapy providers. Refer to the DME and DMS handbook (Part N) for more information.

Wisconsin Medicaid may cover medically necessary DMS used during the course of treatment. Refer to the DMS Index for a list of covered DMS.

J. Communication with Other Medicaid Providers

When a recipient receives similar Medicaid services from therapists and other providers, these providers *must* communicate with each other for the following reasons:

- ✓ To ensure service coordination.
- ✓ To avoid duplication of services.
- ✓ To facilitate continuity of care.

Note: Other Medicaid providers are Medicaid HMOs and fee-for-service providers including other therapists, school-based services (SBS) providers, physician clinics, rehabilitation agencies, local health departments, community mental health agencies, tribal health agencies, and home care agencies.

When a recipient receives services from both SBS and non-SBS therapists, documented communication must occur at least annually. The communication must be documented in the recipient's medical records.

Note: SBS providers are required to cooperate with Medicaid fee-for-service providers who request copies of the child's IEP/IFSP or components of the multi-disciplinary team (M-team) evaluation.

K. Noncovered Services

As specified in HSS 107.16 (4), Wis. Admin. Code, Wisconsin Medicaid does not cover the following physical therapy services:

- ✓ Services related to activities for the general good and welfare of recipients include the following:
  - → General exercises to promote overall fitness and flexibility.
  - → Activities to provide diversion or general motivation.
- ✓ Those services that can be performed by restorative nursing, as specified in HSS 132.60 (1) (b) through (d), Wis. Admin. Code.

K. Noncovered Services (continued)

- ✓ Activities such as end-of-the-day clean-up time, transportation time, consultations and required paper reports (these are considered components of the provider's overhead costs and are not separately reimbursable).
- ✓ Group physical therapy services.
- ✓ Activities performed by a physical therapy aide including the following:
  - → Interpretation of physician referrals.
  - → Patient evaluation.
  - → Evaluation of procedures.
  - → Initiation or adjustment of treatment.
  - → Assumption of responsibility for planning recipient care.
  - → Making entries in recipient records.

As specified in HSS 107.02 (2), Wis. Admin. Code, services which require prior authorization but have not been approved are noncovered services.

As specified in HSS 101.03 (96m), Wis. Admin. Code, services determined by Wisconsin Medicaid as not medically necessary and/or experimental are noncovered services. This includes the following noncovered services:

- ✓ *Facilitated Communication (FC)* - This service is noted as experimental by the American Speech-Language-Hearing Association in ASHA, March 1995. The American Psychological Association, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and the American Association on Mental Retardation concur in policy statements developed in 1993 and 1994.
- ✓ *Auditory Integration Therapy (AIT)* - This service is noted as experimental by the American Speech-Language-Hearing Association in ASHA, November 1994, and the American Academy of Audiology in Audiology Today, July-August 1993.

As specified in HSS 107.16, Wis. Admin. Code, services that can be performed by nursing, active treatment, activity, and caregiver services are noncovered services under Medicaid's therapy benefit.

A. General Requirements

According to HSS 107.02 (3), Wis. Admin. Code, Wisconsin Medicaid requires prior authorization for certain services for the following reasons:

- ✓ Safeguard against unnecessary or inappropriate care and services.
- ✓ Safeguard against excess payment.
- ✓ Assess the quality and timeliness of services.
- ✓ Determine if less expensive alternative care, services, or supplies are usable.
- ✓ Promote the most effective and appropriate use of available services and facilities.
- ✓ Curtail misuse practices of providers and recipients.

Providers need prior authorization for certain specified services *before* delivery unless the service is an emergency. Payment is not made for services provided either before the grant date or after the expiration date indicated on the approved prior authorization request form. If the provider provides a service which requires prior authorization without first obtaining prior authorization, the *provider* is responsible for the cost of the service.

Prior authorization does not guarantee payment. Provider eligibility, recipient eligibility, and medical status on the date of service, and all other Medicaid requirements must be met before the claim is paid.

B. Services Requiring Prior Authorization

When Wisconsin Medicaid Requires Prior Authorization

Wisconsin Medicaid applies the same prior authorization requirements for all therapy providers:

1. Wisconsin Medicaid requires prior authorization for therapy services received from any provider in the recipient's lifetime in excess of 35 days per spell of illness (SOI) (HSS 107.16 (2), HSS 107.17 (2), and HSS 107.18 (2), Wis. Admin. Code).
2. For conditions that do not qualify for an SOI, Wisconsin Medicaid requires prior authorization starting with the first day of treatment.

   Examples include:

   - ✓ Decubitus ulcers.
   - ✓ Mental retardation.
   - ✓ Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing therapeutic services) with or without speech processor programming.
   - ✓ Modification of voice prosthetic or augmentative alternative communication device to supplement oral speech.
3. Wisconsin Medicaid also requires prior authorization starting with the first day of treatment for other circumstances including:

   - ✓ Co-treatment (interdisciplinary treatment).
   - ✓ Procedures shown as unlisted (non-specific) procedures as identified in Medicaid therapy publications.

B. **Services Requiring Prior Authorization** (continued)

Requirements for Electrical Stimulation as Treatment for Decubitus Ulcers

Decubitus ulcers do not qualify as an SOI. When requesting prior authorization for electrical stimulation as treatment for decubitus ulcers, request the service as a manual electrical stimulation procedure. Payment is made only for the face-to-face time that the PT is in attendance.

The prior authorization request must include all of the following documentation:

- ✓ The character, size, etc., of the pressure sore.
- ✓ Weekly measurements.
- ✓ Weekly percentage change in size or healing.
- ✓ The need for additional time for dressing changes or preparation time.

Prior authorization for continuing treatment is considered if formation of granulation tissue or a 25 percent reduction in area has occurred within 45 treatment days. Documentation of nursing protocols, positioning recommendations, and dietary involvement is required when this rapid improvement has not occurred within 45 days.

Co-Treatment (Interdisciplinary Treatment)

All co-treatment requires prior authorization. Each provider involved in co-treatment must complete a separate prior authorization request that identifies the other co-treatment provider and documents the medical necessity of co-treatment. Refer to Section II of this handbook for additional information on covered services.

Co-treatment is approved *only under extraordinary circumstances*. Requests for co-treatment must include documentation justifying why individual treatment from a therapist does not provide maximum benefit to the recipient and why two different kinds of therapy (treating simultaneously) are required. Wisconsin Medicaid recognizes that physical therapy, occupational therapy, and speech pathology each provide a unique approach to the individual's treatment. BHCF medical consultants review all prior authorization requests for co-treatment.

Other Circumstances

Providers should request prior authorization for all services provided to recipients who currently receive, or have previously received, physical therapy services from another certified provider to avoid denial for duplication of services. For example, payment is denied when another provider has a valid prior authorization for therapy services or when payment for physical therapy services is received by another provider under a recipient's first or subsequent SOI.

Physical Therapy Services Provided by Outpatient Hospital Facilities and Home Health Agencies

Prior authorization requirements *in this section* do not apply to *onsite* hospital services and home health agencies. Hospital *offsite* services follow prior authorization and other requirements in this handbook. Refer to the hospital handbook (Part F) for more information about other requirements beyond prior authorization. Physical therapy services provided by a home health agency are subject to other prior authorization requirements under HSS 107.11 (3), Wis. Admin. Code. Refer to the home health handbook (Part L, Division II) for more information about home health physical therapy services.

C. General Prior Authorization Requirements

The following are general prior authorization requirements for physical therapy services:

- ✓ The prior authorization request form must be complete and must contain sufficient information to clearly describe the medical necessity of the services.
- ✓ The services must comply with all state and federal regulations.
- ✓ The attachments, if submitted with the prior authorization request, must have the current date, recipient's name and identification number on each page, and be stapled to the prior authorization forms. Attachments may only supplement the information requested on the forms. The attachments *are not* a replacement for the prior authorization request forms.

Refer to Appendices 9, 9a, 10, and 10a of this handbook for more information.

D. Other Limitations

As specified in HSS 107.16 (3) (e), Wis. Admin. Code, extension of therapy services (e.g., additional therapy services) is not approved beyond the 35 treatment-day prior authorization threshold per SOI in any of the following circumstances:

- ✓ The recipient shows no progress toward meeting or maintaining established and measurable treatment goals over a six-month period. Or, the recipient shows no ability within six months to carry over abilities gained from treatment in a facility to the recipient's home.
- ✓ The recipient's chronological or developmental age, way of life, or home situation, indicates the stated goals are not appropriate for the recipient or serve no functional or maintenance purposes.
- ✓ The recipient has achieved independence in daily activities or can be supervised and assisted by restorative nursing personnel.
- ✓ The evaluation indicates the recipient's abilities are functional for the recipient's present way of life.
- ✓ The recipient shows no motivation, interest, or desire to participate in therapy, which may be for reasons of an overriding severe emotional disturbance.
- ✓ Other therapies are providing sufficient services to meet the recipient's functioning needs. Or, the procedures are one of the following:
  - → Not medical in nature.
  - → Experimental or research.
  - → Noncovered services.
  - → Determined by Wisconsin Medicaid to be medically unnecessary.

E. Completion of Prior Authorization Request Form (PA/RF) and Prior Authorization Therapy Attachment Form (PA/TA)

- ✓ The prior authorization request form must be filled out completely (i.e., all sections completed). The request and attached documents must include the following:
- ✓ The request must be accompanied by a physician's signature (a copy of the physician's order sheet dated within 90 days of its receipt by the fiscal agent indicating the physician's signature is acceptable). If the required documentation is missing from the request form, the request is returned to the provider for the missing information.

E. Completion of Prior Authorization Request Form (PA/RF) and Prior Authorization Therapy Attachment Form (PA/TA) (continued)

- ✓ A written report of the evaluation results and recommendations must be attached to the prior authorization request.
- ✓ The treatment plan must contain specific measurable goals including written instructions for follow-through or carryover by the recipient and/or caregiver. Carryover or follow-through is to be realistically achievable by the recipient and/or caregiver both at the place of residence for a recipient and other programs (e.g., in a facility for the developmentally disabled, nursing home, sheltered workshop, etc.). If carryover is not possible within six months of initiating treatment, continued authorization per the Wisconsin Administrative Code may not be approved.
- ✓ Progress statements must include information relating to progress in motor, sensory integrative and cognitive areas, and performance of independent living/ functional skills. Progress statements must be specific, objective, and measurable.
- ✓ If therapy is being requested for a school-age child *outside of* or *in addition* to school system therapy, the following must be included:
  - → A copy of the therapy IEP and the comprehensive therapy evaluation contained in the M-Team Report must be attached to the prior authorization request for the purpose of coordination and integration of the educational and medical needs of the child.
  - → If no therapy IEP or IEP M-Team therapy evaluation exists, information justifying the reason for the absence of school therapy must be submitted.
  - → Documentation substantiating the medical necessity of proposed therapy and the procedure for coordinating the treatment plan between therapists must be submitted.
- ✓ If therapy is requested for a recipient in a facility for the developmentally disabled (FDD), a copy of the Interdisciplinary Program Plan (IPP) must be attached to the prior authorization request to document coordination and integration of the active treatment and medical care plan of the recipient.
- ✓ Indicate the requested start date for therapy services to the right of element 24 on the PA/RF form.

F. Modifiers

Medicaid Modifier for Physical Therapy Procedure Codes

PTs, rehabilitation agencies, and therapy groups must add modifiers when requesting prior authorization for *all* physical therapy services.

Modifiers allow therapists and Wisconsin Medicaid to distinguish between physical and occupational therapy services with identical procedure codes. The modifier for physical therapy procedure codes is "PT."

How to Request Prior Authorization Using Modifiers

Enter the "PT" modifier on the PA/RF, in addition to all the other required elements, for physical therapy services under the new coding structure.

Refer to Appendices 9 and 9a for a PA/RF claim form sample and PA/RF completion instructions.

F. Modifiers (continued)

How to Request a New Spell of Illness (SOI) Using Modifiers

Include elements 14-19 on the PA/RF when requesting approval of a new SOI for physical therapy services under the new coding structure. This is in addition to all other required elements on the PA/RF. Refer to Appendices 11 and 11a for a PA/RF SOI sample and completion instructions.

SOIs authorized under deleted codes are not paid for dates of service after December 31, 1995.

You must amend PA/RFs with a Prior Authorization Spell of Illness Attachment (PA/SOIA) for dates of service after December 31, 1995. Amend the PA/RF by using the new coding structure and adding PA/RF elements 14 - 19 or complete a prior authorization request under the new coding structure. Refer to Appendices 12 and 12a for a PA/SOIA sample and completion instructions.

G. Additional Information Relating to Prior Authorization

Section VIII of Part A, the all-provider handbook, identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, transferring authorization, supporting materials, retroactive authorization, recipient loss of eligibility midway in treatment, and prior authorization for out-of-state providers.

Multiple Providers

If more than one physical therapy provider from different agencies requests dual-treatment for one recipient, each provider must complete a separate PA/RF. The BHCF processes the requests *at the same time*. In addition to completion of the required prior authorization elements, include the following information:

- ✓ The reason for the dual-certification.
- ✓ The specific days of the week each provider administers the service.
- ✓ The procedure for the coordination of the treatment plan.

Change of Provider

An approved prior authorization may be transferred by the fiscal agent from the provider who obtained the approved prior authorization to another provider. The transfer may occur when medically necessary and when new ownership of a provider or a change in the billing provider number occurs. In all other circumstances when a recipient goes to a new provider, a new prior authorization must be requested.

The provider requesting transfer of the prior authorization must send all of the following to the fiscal agent:

- ✓ A copy of the current PA/RF.
- ✓ A new PA/RF which is *completely* filled out and indicates the "new" provider's name and provider number.
- ✓ A cover letter attached to the packet of PA/RFs that the provider sends to the fiscal agent. The cover letter must include the following information:
  - → The specific reason for the change of provider.
  - → The previous provider's name.

G. Additional Information Relating to Prior Authorization (continued)

- ➔ The new provider's name and provider number.
- ➔ The effective date of the transfer.

Providers must observe professional courtesy by sharing information for administrative purposes. The expiration date of the current prior authorization and the grant date of the new prior authorization are based on the effective date in the cover letter.

Review of Prior Authorization Decisions

When a provider disagrees with a prior authorization disposition, the provider may request an informal review by one of several methods:

- ✓ If a prior authorization has been approved with modification, submit a letter to amend the therapy request. Include all information that supports the request. Call the fiscal agent therapy consultant, if appropriate, before submitting the amendment form to discuss the pertinent issues. If the amendment is approved, the approval date is the date when the amendment request is received by the fiscal agent. It must be received within two weeks of the date the prior authorization is signed by the consultant (process date) on the original PA/RF.
- ✓ If a prior authorization has been denied, providers may, if appropriate, call the fiscal agent consultant to discuss the decision. If the fiscal agent consultant changes the decision based on additional clarifying information, a new prior authorization must be submitted with the additional documentation the consultant requires to change the denial. This information must be submitted to the fiscal agent within two weeks of the process date on the denied PA/RF. This request may be backdated to the first fiscal agent receipt date of the original denied prior authorization when the grant date is requested and the denied request is referred to in writing.

If the consultant does not change the denial, the *recipient* has the right to appeal through the fair hearing process as instructed in the denial letter. Recipients are notified of the denial and their right to appeal in writing.

Amending Approved Prior Authorization Requests

When medically necessary, providers may request amendments of valid prior authorizations to change the frequency of treatment, the specific treatment codes, or the grant or expiration dates. Changes to the original prior authorization request are based on changes in the recipient's medical condition (i.e., necessary increases or decreases in frequency, a different array of treatment codes found in the plan of care or extending the expiration date).

Valid prior authorizations are not amended to accommodate vacations or leaves of absence by either the recipient or provider. Prior authorization expiration dates may be amended up to one month beyond the original expiration date. The amendments may be done if the services are medically necessary and will be discontinued after a brief extension of the therapy services. However, if therapy is continued, it is recommended that a new prior authorization be submitted rather than go through the amendment process.

Providers amending prior authorization requests must do all of the following:

- ✓ Write a letter to the fiscal agent requesting an amendment to the approved prior authorization.

G. Additional Information Relating to Prior Authorization (continued)

- ✓ In sufficient detail, describe the reason for the request so Wisconsin Medicaid can determine its medical necessity.
- ✓ Describe in detail the specific change requested.
- ✓ Attach a copy of the approved prior authorization.
- ✓ Attach supporting clinical documentation.

Send the amendment request to:

EDS
Attn: Prior Authorization, Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Amendment Request Approval Criteria
Amendment requests may be approved if the request is medically necessary under HSS 101 (96m), Wis. Admin. Code, submitted before the date of the requested change, and fully explained and documented in the request. Clinical documentation of the medical necessity amendment request is required.

Following is an example of an amendment request that may be approved:

- ✓ A brief (less than one month) extension of the original approved prior authorization is requested. The brief extension occurs only when the recipient's medical condition is reasonably anticipated to improve during the extension period such that similar services will not be medically necessary following the requested extension (i.e. the provider is not expected to submit a new prior authorization request for similar services following the extension).

Amendment Request Denial Criteria
Amendment requests are denied if they are not medically necessary.

Requests are denied for the following reasons:

- ✓ Solely for the convenience of the recipient, the recipient's family, or the provider.
- ✓ Not received before the date of the requested change.
- ✓ Extending an approved prior authorization expiration date when the recipient's medical condition changes significantly, requiring a new plan of care.
- ✓ where similar services are expected to be medically necessary following the expiration date of the original approved prior authorization.

Note: At the end of a possible extension period, providers must submit a new prior authorization request instead of requesting an extension if one of the following occurs:

- → The recipient's medical condition changes significantly requiring a new plan of care
- → Similar services are expected to be medically necessary.

G. Additional Information Relating to Prior Authorization (continued)

Obtaining Prior Authorization

Sample prior authorization request forms along with their completion and submittal instructions are in Appendices 9 through 13 of this handbook.

Send completed prior authorization request forms to:

EDS
Attn: Prior Authorization Unit - Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Order prior authorization request forms from:

EDS
Attn: Form Reorder
6406 Bridge Road
Madison, WI 53784-0003

Please specify the prior authorization form and number desired. Reordered forms are included with form shipments. Do not request prior authorization forms by telephone.

H. HealthCheck "Other Services"

Medically necessary services which are not otherwise covered by Wisconsin Medicaid may be covered if they are provided to a recipient under age 21 as a result of a HealthCheck examination.

To request prior authorization for HealthCheck "Other Services," do:

- ✓ Submit a PA/RF.
  - → Indicate on the PA/RF that the request is for HealthCheck "Other Services."
  - → Wisconsin Medicaid assigns a procedure code if the service is approved.
- ✓ Submit the Prior Authorization Therapy Attachment (PA/TA) which clarifies the service and medical necessity of the service with the PA/RF.
- ✓ Include a signed and dated statement by the HealthCheck screener or an indication that the recipient received a HealthCheck screen.

The screen must have been performed within one year of the date of fiscal agent receipt of the prior authorization request. Also, the service must be a covered service under federal regulations.

A. Coordination of Benefits

Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. If the recipient is covered under other health insurance (including Medicare), Wisconsin Medicaid pays that portion of the allowable cost remaining after exhausting all other health insurance sources. Refer to Section IX of Part A, the all-provider handbook, for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

B. Medicare/ Medicaid Dual Entitlement

Recipients covered under both Medicare and Wisconsin Medicaid are known as dual-entitlees. Claims for Medicare-covered services provided to dual-entitlees must be billed to Medicare *before* billing Wisconsin Medicaid.

If the service for a recipient is covered by Medicare, but Medicare denies the claim, indicate a Medicare disclaimer code on the HCFA 1500 claim form. Although services covered by Medicare do not require prior authorization, providers are strongly encouraged to obtain prior authorization for dual-entitlees either at the time of initial Medicare claim submission or following a postpayment reconsideration. This ensures Medicaid payment if Medicare denies coverage.

Therapy Crossovers Subject to Medicaid Payment Limitations

Payments on certain therapy crossover claims from Medicare for dual-entitlees are subject to Medicaid maximum allowable fees and rates. Refer to Section IX of Part A, the all-provider handbook, for more information.

C. QMB-Only Recipients

Qualified Medicare Beneficiary Only (QMB-only) and Qualified Medicare Beneficiary-Nursing Home (QMB-NH) recipients are only eligible for Medicaid payment of the coinsurance and the deductibles for Medicare-covered services. If services are denied by Medicare, they are *not* covered by Wisconsin Medicaid.

D. Referring Provider

Claims for physical therapy services require the referring provider's name and UPIN number in elements 17 and 17a of the HCFA 1500 claim form. Refer to Appendix 1b of this handbook for billing instructions.

E. Reimbursement Methodology

Maximum Allowable Fees Based on Relative Value Units (RVUs)

Medicaid maximum allowable fees for CPT-4 and HCPCS codes for physical therapy procedures are based on the national standard Medicare Relative Value Units (RVUs).

The resource-based relative value scale (RBRVS) assigns RVUs based on the complexity of procedures. The RBRVS takes into account the provider's work for each procedure, practice expenses, and liability insurance. The work component includes the physical and mental intensity used to perform the service, the time taken to perform the service, and the pre- and post-face-to-face work associated with a typical encounter.

The work RVUs for services are based on the expectation that the code's definition represents exactly how the service is furnished when billed to Wisconsin Medicaid.

F. Payment Methods

Conversion of Therapy Treatment Time to Medicaid Treatment Units for Billing Purposes

For dates of service on and after September 1, 1995, the treatment unit of service is defined by the procedure code description. For example, when the description includes the statement 'each 15 minutes,' then one treatment unit of service is 15 minutes. If the description does not specify a time, the entire procedure, per date of service, equals one treatment unit of service. Part of a unit may be billed by using a number with a decimal point. Refer to Appendix 5 of this handbook for conversion charts. (Use the conversion charts applicable to the date of service.)

F. Payment Methods (continued)

Bill Face-to-Face Treatment Time Only

Bill the face-to-face treatment time actually provided. For example, if the procedure code description references 15 minutes of direct treatment, the provider must have furnished 15 minutes of direct, face-to-face treatment to the individual recipient to bill one unit of service.

Activities Included in a Treatment Unit

Based on CPT code definitions, only time spent in face-to-face treatment services to the individual recipient may be included in a Medicaid treatment unit.

Examples of face-to-face treatment time include the following:

- ✓ Time to obtain and update a history with the recipient present.
- ✓ Performing evaluation tests and measures with the recipient present.
- ✓ Face-to-face delivery of the physical therapy service to the recipient.

Non-face-to-face time is not included in a treatment unit. Examples of non-face-to-face treatment time include the following:

- ✓ Time to review records, score evaluation tests, and measures.
- ✓ Communication with other professionals, staff, and caregivers.

Non-face-to-face time is included in the reimbursement for the face-to-face service, as described under "Payment Methods."

G. Daily Service Limitations

Ninety-Minute Daily Coverage Limitations

As specified in HSS 101.03 (96m) and HSS 107.02 (2) (b), Wis. Admin. Code, Wisconsin Medicaid does not cover physical therapy services beyond 90 minutes per day unless coverage of additional medically necessary treatment is requested and approved through the claims adjustment process (see the next paragraph). This limit is based on the determination that physical therapy services in excess of 90 minutes per day generally exceed the medically necessary, reasonable, and appropriate duration of physical therapy services.

If, under extraordinary circumstances, physical therapy treatment is necessary beyond the limitation of 90 minutes per day, coverage of additional treatment time may be requested by submitting an adjustment request form after the claim is paid. The specific medical reason for exceeding the 90-minute limitation must be documented on the adjustment request form. Refer to Section X and Appendices 27 and 27a of Part A, the all-provider handbook, for information on submitting an adjustment request.

Daily Unit of Service Limitation

Wisconsin Medicaid covers some procedure codes only a limited number of times a day. Refer to 'Daily Unit of Service Limit' in Appendix 4 of this handbook for specific limits.

H. Billed Amounts

Providers must bill their usual and customary charge for services provided. The usual and customary charge is the amount the provider charges for the same service when provided to a private-pay patient. For providers using a sliding fee scale for specific services, the usual and customary charge is the provider's charge for the service when provided to a private-pay patient. Providers may not discriminate against a Medicaid recipient by charging a higher fee for the service than is charged to a private-pay patient.

H. Billed Amounts (continued)

Do not reduce the billed amount by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the Medicaid-allowed payment.

I. Claim Submission

Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent can process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as paper claims. Providers submitting electronically usually reduce their claim submission errors. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Paper Claim Submission

Submit procedure codes for physical therapy services on the HCFA 1500 claim form. A sample HCFA 1500 claim form and completion instructions are in Appendices 1, 1a, and 1b of this handbook.

Procedure codes for physical therapy services submitted on any other paper form than the HCFA 1500 claim form are denied.

The HCFA 1500 claim form is not provided by Wisconsin Medicaid or the fiscal agent. Claim forms are available from many suppliers, including:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Mail completed claims submitted for payment to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

The fiscal agent must receive all claims for services rendered to eligible recipients within 365 days from the date of the service. This policy pertains to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals are in Section IX of Part A, the all-provider handbook.

J. Diagnosis Codes

All diagnoses must be from *the International Classification of Diseases, 9th Edition, Clinical Modifications* (ICD-9-CM) coding structure.

Claims received without the appropriate ICD-9-CM code are denied.

Order the complete ICD-9-CM code book by writing to the address in Appendix 3 of Part A, the all-provider handbook.

J. Diagnosis Codes (continued)

Providers must note the following diagnosis code restrictions:

- ✓ Do not use codes with an "E" prefix as the primary or sole diagnosis on the HCFA 1500 claim form.
- ✓ Codes with an "M" prefix are not acceptable on the HCFA 1500 claim form.

K. Medicaid Procedure Codes

All HCFA 1500 claim forms require HCFA Common Procedure Coding System (HCPCS) codes. Claims or adjustments received without the appropriate codes are denied.

Medicaid Physical Therapy Procedure Codes

Refer to Appendix 4 of this handbook for Medicaid HCPCS procedure codes for billing and prior authorization for dates of service on and after September 1, 1995. Wisconsin Medicaid will notify providers when Wisconsin Medicaid adopts changes to these procedure codes.

Refer to Appendix 4 of this handbook for procedure codes for billing physical therapy services for dates of service before September 1, 1995.

Billing Evaluation Services in Facilities for the Developmentally Disabled

Effective September 1, 1995, evaluation services in facilities for the developmentally disabled (FDD) use HCPCS comprehensive evaluation procedure codes. Refer to Appendix 4 of this handbook for HCPCS procedure codes.

L. Modifiers

How to Bill Using Modifiers

PTs, rehabilitation agencies, and therapy groups must add modifiers when billing for *all* physical therapy services.

Modifiers allow PTs and Wisconsin Medicaid to distinguish between physical and occupational therapy services with identical procedure codes. The modifier for physical therapy procedure codes is "PT."

Paper Claims Submission

Enter the "PT" modifier in element 24d on the HCFA 1500 claim form or the claim will deny.

Paperless Claim Submission

Enter the "PT" modifier immediately after the procedure code in field "M1," or the claim will deny.

For example, a PT bills procedure code 97119 (therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility). The PT enters the "PT" modifier in element 24d on the HCFA 1500 claim form.

M. Follow-up to Claim Submission

To ensure that your claim is not denied, complete the claim form using:

- ✓ The *same* prior authorization number that is on the PA/RF.
- ✓ The *same* modifier for the same procedure code that is on the PA/RF.

M. Follow-up to Claim Submission (continued)

Providers are responsible for initiating follow-up procedures on claims submitted to the fiscal agent. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Refer to Appendix 17, for a list of EOB codes (denial codes), how to avoid claim denials, and a sample Remittance and Status Report with EOB codes. The fiscal agent takes no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A, the all-provider handbook, includes detailed information regarding the following:

- ✓ The Remittance and Status Report.
- ✓ Adjustments to paid claims.
- ✓ Return of overpayments.
- ✓ Duplicate payments.
- ✓ Denied claims.
- ✓ Good Faith claims filing procedures.

Refer to Appendix 14 of this handbook for helpful hints for working with Wisconsin Medicaid.

Appendix 1
National HCFA 1500 Claim Form Sample
(Physical Therapy)

APPROVED OMB-0938-0008

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 435.9 3.
2. 437.0 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 95	06 08 95	7	1	97116	PT	1	XX XX	8.0				12345600
2 02 23 95		7	1	97110	PT	2	XX XX	1.0				12345600
3 02 01 95		7	1	97265	PT	1	XX XX	2.0				12345600
4												
5												
6												Recipient Spenddown

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ XXX.XX

29. AMOUNT PAID $ XX.XX

30. BALANCE DUE $ XX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Provider MM/DD/YY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
I.M. Nursing Home
506 Willow
Anytown, WI 55555

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Billing
1 W. Williams
Anytown, WI 55555 87654300
PIN# GRP#

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 1a
National HCFA 1500 Claim Form Sample
(Rehabilitation Agency)

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) M | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M | F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 435.9 3.

2. 437.0 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 95	06 08 95	7	1	97116	PT	1	XX XX	8.0				
2 02 23 95		7	1	97110	PT	2	XX XX	1.0				
3 02 01 95		7	1	97265	PT	1	XX XX	2.0				
4												
5												
6												Recipient Spenddown

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ XXX.XX

29. AMOUNT PAID $ XX.XX

30. BALANCE DUE $ XX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

I.M. Nursing Home
506 Willow
Anytown, WI 55555

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654300

PIN# GRP#

PATIENT AND INSURED INFORMATION — CARRIER — PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 1b
National HCFA 1500 Claim Form Completion Instructions for Physical Therapy Services and Rehabilitation Agencies

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Medicaid recipients receive an identification card when initially enrolled into Wisconsin Medicaid and at the beginning of each following month. Providers must always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Element 1 - Program Block/Claim Sort Indicator
Enter the claim sort indicator:

"T" - Physical Therapy Services.
"M" - Rehabilitation Agency.

Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. Number
Enter the recipient's 10-digit identification number from the current identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim. In this case, the recipient's Medicare number may also be indicated.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial from the current identification card.

Element 3 - Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (i.e., February 3, 1955, would be 02/03/55) from the identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient Relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
Bill health insurance (commercial insurance coverage) before billing Wisconsin Medicaid unless the service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook.

✓ Leave this element blank when the provider has not billed the other health insurance because the "Other Coverage" of the recipient's identification card is blank, the service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook, or the recipient's identification card indicates "DEN" only.

✓ When "Other Coverage" of the recipient's identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A, the all-provider handbook, one of the following codes MUST be indicated in the *first* box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by the health insurance. The amount paid by the health insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by the health insurance company following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the health insurer.
OI-Y	YES, the card indicates other coverage but it was not billed for reasons including, but not limited to the following: ➔ Recipient denies coverage or will not cooperate. ➔ The provider knows the service in question is noncovered by the carrier. ➔ The health insurance failed to respond to initial and follow-up claim. ➔ Benefits not assignable or cannot get an assignment.

✓ When "Other Coverage" of the recipient's identification card indicates "HMO" or "HMP", indicate one of the following disclaimer codes, if applicable.

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is entered on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not provided by a designated provider. Wisconsin Medicaid does not pay for services covered by an HMO or HMP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 - Is Patient's Condition Related to (not required)

Element 11 - Insured's Policy, Group, or FECA Number

Use the *first* box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed before billing Wisconsin Medicaid. When the recipient's identification card indicates Medicare coverage, but Medicare does not pay, indicate one of the following Medicare disclaimer codes. The description is not required.

Code	*Description*
M-1	Medicare benefits exhausted. This code applies when Medicare has denied the claim because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.

Use M-1 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A but is denied due to benefits being exhausted.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B but is denied due to benefits being exhausted.

M-5 Provider not Medicare-certified. This code applies when the provider is not required by Wisconsin Medicaid to be Medicare Part A or Part B certified, has chosen not to be Medicare Part A or Part B certified or cannot be Medicare Part A or Part B certified.

Use M-5 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is not certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is not certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B.

M-6 Recipient not Medicare-eligible. This code applies when Medicare denied the claim because there is no record of the recipient's eligibility. Use M-6 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The service is covered by Medicare Part A.
- The recipient is not eligible for Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The service is covered by Medicare Part B.
- The recipient is not eligible for Medicare Part B.

M-7 Medicare disallowed or denied payment. This code applies when Medicare actually denies the claim for reasons given on the Medicare remittance advice. Use M-7 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A, but is denied by Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B, but is denied by Medicare.

M-8 Noncovered Medicare service. This code applies when Medicare was not billed because Medicare does not cover the service at this time. A list of services that are not covered under Medicare is in Appendix 16 of Part A, the all-provider handbook.

Nursing homes must use M-8 for Medicare-eligible recipients who are hospitalized and do not wish to return to a Medicare-covered bed.

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is not covered under Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is not covered under Medicare Part B.

Leave the element blank if Medicare is not billed because the recipient's Medicaid identification card indicated no Medicare coverage.

Leave the element blank if Medicare allows an amount on the recipient's claim. Attach the Explanation of Medicare Benefits (EOMB) to the claim. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A, the all-provider handbook, for more information about the submission of claims for dual-entitlees.

Elements 12 and 13 - Authorized Person's Signature
(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient Has Had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source
Enter the referring or prescribing physician's name.

Element 17a - I.D. Number of Referring Physician
Enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the Medicaid provider number or license number of the referring provider. Refer to Appendix 3 of Part A, the all-provider handbook, for the UPIN directory address.

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use
If an unlisted procedure code is billed, describe the procedure. If element 19 does not provide enough space for the procedure description, or if multiple unlisted procedure codes are being billed, attach documentation to the claim describing the procedure(s). In this instance, indicate "See Attachment" in element 19.

Element 20 - Outside Lab (not required)

Element 21 - Diagnosis or Nature of Illness or Injury
Enter *the International Classification of Disease* (ICD) diagnosis code for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization

Enter the seven-digit prior authorization number from the approved prior authorization request form. Bill services authorized under multiple prior authorizations on separate claim forms with their respective prior authorization numbers.

Element 24a - Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines.

✓ When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.

✓ When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (e.g., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if all of the following apply:

✓ All dates of service are in the same calendar month.
✓ All services are billed using the same procedure code and modifier, if applicable.
✓ All procedures have the same type of service code.
✓ All procedures have the same place of service code.
✓ All procedures were performed by the same provider.
✓ The same diagnosis is applicable for each procedure.
✓ The charge for each procedure is identical. (Enter the total charge *per detail line* in element 24f.)
✓ The number of services performed on each date of service is identical.
✓ All procedures have the same HealthCheck indicator.
✓ All procedures have the same emergency indicator.

Element 24b - Place of Service

Enter the appropriate *single-digit* place of service code for each service. Refer to Appendix 3 of this handbook for a list of allowable place of service codes for physical therapy services.

Element 24c - Type of Service Code

Enter the appropriate single-digit type of service code. Refer to Appendix 3 of this handbook for a list of allowable type of service codes for physical therapy services.

Element 24d - Procedures, Services, or Supplies

Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers. Refer to Appendix 3 of this handbook for a list of allowable procedure codes for physical therapy services.

Element 24e - Diagnosis Code

When multiple procedures related to different diagnoses are submitted, use column E to relate the procedure performed (element 24d) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges

Enter the total charge for each line.

Element 24g - Days or Units

Enter the total number of services billed for each line. Physical therapy services must be billed following the *Conversion of Therapy Treatment Time Guidelines* in Appendix 5 of this handbook.

Element 24h - EPSDT/Family Planning
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

Element 24i - EMG
Enter an "E" for *each* procedure performed as an emergency, regardless of the place of service. If the service is not an emergency, leave this element blank.

Element 24j - COB (not required)

Element 24k - Reserved for Local Use
Enter the eight-digit provider number of the performing provider *for each procedure*, if it is different than the billing provider number indicated in element 33.

Note: Rehabilitation agencies do not indicate a performing provider number.

When applicable, enter the word "spenddown" and under it, enter the spenddown amount on the last detail line of element 24k directly above element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No.
Optional - The provider may enter up to 12 characters of the patient's internal office account number. This number appears on the fiscal agent Remittance and Status Report.

Element 27 - Accept Assignment
(Not required, provider automatically accepts assignment through Medicaid certification.)

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount Paid
Enter the amount paid by the health insurance. If the other health insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

Element 30 - Balance Due
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24k and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier
The provider or an authorized representative must sign in element 31. Also enter the month, day, and year the form is signed in MM/DD/YY format.

Note: This may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit provider number.

Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code, and Telephone
Enter the billing provider's name (exactly as indicated on the provider's notification of certification letter) and address. At the bottom of element 33, enter the billing provider's eight-digit provider number.

Appendix 2
Electronic Media Claims (EMC) Screen

WELCOME TO ELECTRONIC CLAIMS SUBMISSION DATE 010193

EDS - WISCONSIN MEDICAID

BP NBR 33 L NAME 2 F NAME 2 MID 1A

PCN 26 OI 9 TPL 10 MSC 11 PA NBR 23

RP NBR 17 FP NBR 32 OP NBR

DIAG 1 21.1 2 21.2 3 21.3 4 21.4 5 21.5

DTL	FDOS	A1A2A3	POS	PROC	M1	M2	PP NBR	DX	CHARGE	UNIT	TOS	EMG	H/F
1	24.3	A	B	D	D	D	K	E	F	G	C	I	H
2													
3													
4													
5													
6													
7													
8													
9													
10													

TOT BILL 28 OI PAID 29 PAT PAID 24.K NET BILL 30

Doc #1 Page #1 Field #6 Form: MEDVENDR 01-01-1993 10:17:35

BENEFITS OF ELECTRONIC BILLING

One of the greatest benefits of electronic billing is that less information is required for processing. Less information means less room for error. The data elements that are not required on electronic claims include the following:

- ✓ Claim indicator.
- ✓ Patient's date of birth.
- ✓ Patient's address.
- ✓ Patient's sex.
- ✓ Signature of provider.
- ✓ Provider's name and address.

Other benefits of billing electronically include:

- ✓ Free software.
- ✓ Improved cash flow.
- ✓ Lower detail denial rate.
- ✓ Flexible submission methods.
- ✓ Claim entry controlled by provider.
- ✓ Online edits.

To request more information on electronic claims submission contact the Electronic Media Claims (EMC) Department at the address located in Section IV of this handbook.

Appendix 3
Wisconsin Medicaid
Place of Service (POS) and Type of Service (TOS) Codes for Physical Therapy Services, Rehabilitation Agencies, Independent Therapists, Therapy Clinics, and Therapy Groups*

Wisconsin Medicaid Allowable POS Codes	
POS Code	**Description**
0	Other
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

Wisconsin Medicaid Allowable TOS Codes	
TOS Code	**Description**
1	Medical (Physical Therapy Services)
9	Rehabilitation Agency Services

* Therapy services provided at a licensed outpatient hospital facility are billed and prior authorized under other POS and TOS. Refer to the Medicaid hospital provider handbook (Part F) for more information.

Appendix 4
Wisconsin Medicaid Allowable HCPCS Procedure Codes and Copayments* for Physical Therapy Services
(For dates of service on and after September 1, 1995)

Deleted Codes	Procedure Codes	Description	Copayment	Daily Treatment Unit Limit	Procedure Codes Allowed by PTAs
Other Procedures					
97100 97200	93797	Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session) (15 minutes)	$1.00	1 per day	Not Allowed
97100 97200	93798	Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session) (15 minutes)	$2.00	1 per day	Not Allowed
97100 97200	94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation (30 minutes)	$1.00	1 per day	Allowed
97100 97200	94668	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent (30 minutes)	$1.00	1 per day	Allowed
97100 97200	94650	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation (15 minutes)	$1.00	1 per day	Not Allowed
97100 97200	94651	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; subsequent (15 minutes)	$1.00	1 per day	Not Allowed
97100 97200	94652	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; newborn infants (15 minutes)	$1.00	1 per day	Not Allowed
Modalities					
97000 97200	97010	Application of a modality to one or more areas; hot or cold packs (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97012	Application of a modality to one or more areas; traction, mechanical (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97014	Application of a modality to one or more areas; electrical stimulation (unattended) (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97016	Application of a modality to one or more areas; vasoneumatic devices (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97018	Application of a modality to one or more areas; paraffin bath (15 minutes)	$1.00	1 per day	Allowed

* Therapy services provided at a licensed outpatient hospital facility are billed and prior authorized under other Medicaid procedure codes. Refer to the Medicaid hospital provider handbook (Part F) for more information.

Deleted Codes	Procedure Codes	Description	Copayment	Daily Treatment Unit Limit	Procedure Codes Allowed by PTAs
Modalities					
97000 97200	97020	Application of a modality to one or more areas; microwave (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97022	Application of a modality to one or more areas; whirlpool (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97024	Application of a modality to one or more areas; diathermy (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97026	Application of a modality to one or more areas; infrared (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97028	Application of a modality to one or more areas; ultraviolet (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97032	Application of a modality to one or more areas; electrical stimulation (manual) (15 minutes)	$1.00	Not Applicable	Allowed
97000 97200	97033	Application of a modality to one or more areas; iontophoresis (15 minutes)	$1.00	Not Applicable	Allowed
97000 97200	97034	Application of a modality to one or more areas; contrast baths (15 minutes)	.50¢	Not Applicable	Allowed
97000 97200	97035	Application of a modality to one or more areas; ultrasound (15 minutes)	$1.00	Not Applicable	Allowed
97000 97200	97036	Application of a modality to one or more areas; Hubbard tank (15 minutes)	$1.00	Not Applicable	Allowed
97000 97200	97039	Unlisted modality (specify type and time if constant attendance) (15 minutes)	$1.00	1 per day	Allowed
97100 97200	90900	Biofeedback training; by electromyogram application (e.g., in tension headaches, muscle spasms) (30 minutes)	$3.00	1 per day	Allowed
Therapeutic Procedures					
97100 97200	97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility	$1.00	Not Applicable	Allowed
97100 97200	97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, proprioception	$1.00	Not Applicable	Allowed

Deleted Codes	Procedure Codes	Description	Copayment	Daily Treatment Unit Limit	Procedure Codes Allowed by PTAs
Therapeutic Procedures					
97100 97200	97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	$1.00	Not Applicable	Allowed
97100 97200	97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training	$1.00	Not Applicable	Allowed
97100 97200	97122	Therapeutic procedure, one or more areas, each 15 minutes; traction, manual	$1.00	Not Applicable	Allowed
97100 97200	97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)	$1.00	Not Applicable	Allowed
97100 97200	97139	Therapeutic procedure, one or more areas, each 15 minutes; unlisted therapeutic procedure (specify)	$1.00	Not Applicable	Allowed
97100 97200	97250	Myofascial/soft tissue mobilization, one or more regions (30 minutes)	$2.00	1 per day	Not Allowed
97100 97200	97265	Joint mobilization, one or more areas (peripheral or spinal) (15 minutes)	$2.00	1 per day	Not Allowed
97100 97200	97520	Prosthetic training; initial 30 minutes, each visit	$1.00	1 per day	Allowed
97100 97200	97521	Prosthetic training; each additional 15 minutes	$1.00	Not Applicable	Allowed
97100 97200	97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance); each 15 minutes	$1.00	Not Applicable	Allowed
97100 97200	97540	Training in activities of daily living (self care skills and/or daily life management skills); initial 30 minutes, each visit	$2.00	1 per day	Allowed
97100 97200	97541	Training in activities of daily living (self care skills and/or daily life management skills); each additional 15 minutes	$1.00	Not Applicable	Allowed
Comprehensive Evaluation					
97700	Q0103	Physical therapy evaluation; initial (90 minutes)	$2.00	1 per day	Not Allowed
97700	Q0104	Physical therapy re-evaluation; periodic (30 minutes)	$1.00	1 per day	Not Allowed

Physical Therapy Procedure Codes *For dates of service before September 1, 1995*			
Procedure Code	**Modifier**	**Description**	**Copayment**
97000	n/a	Physical Therapy Treatment, single modality (30 minutes)	$1.00
97100	n/a	Physical Therapy Treatment, single procedure (30 minutes)	$1.00
97200	n/a	Physical Therapy Treatment, two or more or a combination of modalities, procedures, evaluations (30 minutes)	$1.00
97700	n/a	Evaluation (30 minutes)	$1.00
*W9542	n/a	Federally Required Annual Physical Therapy Evaluation	n/a
		* *Note:* When billing procedure code W9542, use diagnoses 317-319.	

Appendix 5
Conversion of Therapy Treatment Time to Wisconsin Medicaid Treatment Units for Billing Purposes*

The following charts illustrate the calculation of units of time for billing physical therapy services.

Conversion Chart for dates of service before September 1, 1995

For dates of service before September 1, 1995

Treatment Time (in minutes)	**Treatment Unit(s) Billed**
15	0.5
30	1.0
45	1.5
60	2.0
75	2.5
90	3.0

Conversion Charts for dates of service on and after September 1, 1995

CONVERSION TABLE 1
Treatment Time to Treatment Units for Procedure Codes
Referencing "15 Minutes of" in the Procedure Code Description
For dates of service on and after September 1, 1995

Actual Treatment Time (in minutes)	**Treatment Unit(s) Billed**
7.5	0.5
15.0	1.0
22.5	1.5
30.0	2.0
37.5	2.5
45.0	3.0

CONVERSION TABLE 2
Treatment Time to Treatment Units for Procedure Codes
Referencing "30 Minutes of" in the Procedure Code Description
For dates of service on and after September 1, 1995

Actual Treatment Time (in minutes)	**Treatment Unit(s) Billed**
15.0	0.5
30.0	1.0
45.0	1.5
60.0	2.0
75.0	2.5
90.0	3.0

* Therapy services provided at a licensed outpatient hospital facility use different Medicaid treatment units. Refer to the Medicaid provider handbook (Part F) for more information.

Conversion Charts for dates of service on and after September 1, 1995 (continued)

CONVERSION TABLE 3
Treatment Time to Treatment Units for Procedure Codes
Referencing "45 Minutes of" in the Procedure Code Description
For dates of service on and after September 1, 1995

Actual Treatment Time (in minutes)	**Treatment Unit(s) Billed**
15.0	0.3
22.5	0.5
30.0	0.6
45.0	1.0
60.0	1.3
67.5	1.5
75.0	1.6
90.0	2.0

CONVERSION TABLE 4
Treatment Time to Treatment Units for Procedure Codes
Referencing "90 Minutes of" in the Procedure Code Description
For dates of service on and after September 1, 1995

Actual Treatment Time (in minutes)	**Treatment Unit(s) Billed**
30.0	0.3
45.0	0.5
60.0	0.6
75.0	0.8
90.0	1.0

Appendix 6
List of Evaluations, Tests, and Measures

An evaluation (see Appendix 4) consists of one or more tests or measures used in assessing a recipient's needs. A written report of the evaluation results must accompany the test chart/form in the recipient's medical record.

Evaluations are counted toward the 35-day spell of illness prior authorization threshold.

The following list includes tests and measures which may be used in an evaluation.

- ✓ Stress test.
- ✓ Orthotic check-out.
- ✓ Prosthetic check-out.
- ✓ Functional evaluation.
- ✓ Manual muscle test.
- ✓ Isokinetic evaluation.
- ✓ Range of motion measure (goniometric).
- ✓ Length measurement.
- ✓ Electrical tests include the following:
  - → Nerve conduction velocity.
  - → Strength duration curve-chronaxie.
  - → Reaction of degeneration.
  - → Jolly test (twitch tetanus).
  - → "H" test.
- ✓ Respiratory assessment (spirometer, CO_2 exchange, chest expansion).
- ✓ Sensory evaluation.
- ✓ Cortical integration (evaluation).
- ✓ Reflex testing.
- ✓ Pain.
- ✓ Arthokinematic.
- ✓ Coordination evaluation.
- ✓ Posture analysis.
- ✓ Gait analysis.
- ✓ Crutch fitting.
- ✓ Cane fitting.
- ✓ Walker fitting.
- ✓ Splint fitting.
- ✓ Corrective shoe fitting (orthopedic shoe fitting).
- ✓ Brace fitting (assessment).
- ✓ Chronic-obstructive pulmonary disease evaluation.
- ✓ Hand evaluation.
- ✓ Skin temperature measurement.
- ✓ Oscillometric test.
- ✓ Doppler peripheral-vascular evaluation.
- ✓ Developmental evaluations include the following:
  - → Millani-Comparetti evaluation.
  - → Denver Developmental.
  - → Ayres.
  - → Gessell.
  - → Kephart and Roach.
  - → Bazelton Scale.
  - → Bailey Scale.
  - → Lincoln Osteretsky Motion Development Scale.
- ✓ Neuromuscular evaluation.
- ✓ Wheelchair fitting (evaluation, prescription, modification, adaptation).
- ✓ Jobst measurement.
- ✓ Jobst fitting (stockings).
- ✓ Perceptual evaluation.
- ✓ Pulse volume recording.
- ✓ Physical capacities testing.
- ✓ Home evaluation.
- ✓ Garment fitting.

Appendix 7
List of Modalities

A modality (see Appendix 4) consists of treatment involving physical therapy equipment or apparatus which does not require the physical therapist's personal continuous attendance during the periods of use but which does require setting up, frequent observations, and evaluation of the treated part prior to and after treatment. Treatments which are considered modalities include, but are not limited to, the following for payment purposes.

Hydrotherapy

✓ Hubbard tank (unsupervised).

✓ Whirlpool.

Electrotherapy

✓ Biofeedback.

✓ Electrical stimulation (transcutaneous nerve stimulation, medcolator).

Exercise Therapy

✓ Finger ladder.

✓ Overhead pulley.

✓ Restorator.

✓ Shoulder wheel.

✓ Stationary bicycle.

✓ Wall weights.

✓ Wand exercises.

✓ Static stretch.

✓ Elgin table.

✓ N-K table.

✓ Resisted exercise.

✓ PRE.

✓ Weighted exercise.

✓ Orthotron.

✓ Kinetron.

✓ Cybex.

✓ Skate (powder) board.

✓ Sling suspension modalities.

✓ Standing table.

Mechanical Apparatus

✓ Cervical and lumbar traction.

✓ Vasoneumatic pressure treatment.

Thermal Therapy

✓ Baker.

✓ Cryotherapy (ice immersion - cold packs).

✓ Diathermy.

✓ Hot pack - hydrocollator pack.

✓ Infra-red.

✓ Microwave.

✓ Moist air heat.

✓ Paraffin bath.

Appendix 8
List of Procedures

A procedure (see Appendix 4) consists of a treatment (with or without equipment or apparatus) which *does* require the physical therapist's personal continuous attendance. Treatments which are considered procedures for payment purposes include, but are not limited to, the following.

Hydrotherapy

✓ Contrast bath.

✓ Hubbard tank (supervised).

✓ Whirlpool (supervised).

✓ Walking tank.

Electrotherapy

✓ Biofeedback.

✓ Electrical stimulation (supervised).

✓ Electrogalvanic stimulation.

✓ Iontophoresis (ion transfer).

✓ Transcutaneous nerve stimulation (T.N.S.) (supervised).

✓ Hyperstimulation analgesia.

✓ Interferential current.

Exercise

✓ Peripheral vascular exercise (Beurger-Allen).

✓ Breathing exercises.

✓ Cardiac rehabilitation includes the following:
- → Immediate post-discharge from hospital.
- → Conditioning rehabilitation program.

✓ Codman's exercise.

✓ Coordination exercises.

✓ Exercise therapeutic (active, passive, active assistive, resistive).

✓ Frenkel's exercise.

✓ In-water exercises.

✓ Mat exercises.

✓ Neurodevelopmental exercise.

✓ Neuromuscular exercise.

✓ Postnatal exercises.

✓ Postural exercises.

✓ Prenatal exercises.

✓ Range of motion exercises.

✓ Relaxation exercises.

✓ Relaxation techniques.

✓ Thoracic outlet exercises.

✓ Stretching exercise.

✓ Preambulation exercises.

✓ Pulmonary rehabilitation program.

✓ Stall bar exercise.

✓ Back exercises.

✓ Phonophoreses.

Mechanical Apparatus

✓ Intermittent positive pressure breathing (IPPB).

✓ Tilt table (standing table).

✓ Ultrasonic nebulizer.

✓ Ultraviolet.

Procedures (continued)

Thermal

- ✓ Cryotherapy (ice massage) (supervised).
- ✓ Medcosonulator.
- ✓ Ultrasound.

Manual Application

- ✓ Accupressure (shiatsu).
- ✓ Adjustment of traction apparatus.
- ✓ Application of traction apparatus.
- ✓ Manual traction.
- ✓ Massage.
- ✓ Mobilization.
- ✓ Perceptual facilitation.
- ✓ Percussion (tapotement), vibration.
- ✓ Strapping (taping, bandaging).
- ✓ Stretching.
- ✓ Splinting.
- ✓ Casting.

Neuromuscular Techniques

- ✓ Balance training.
- ✓ Muscle reeducation.
- ✓ Neurodevelopmental techniques (PNF, Rood, Temple-Vay, Doman-Delacato, Cabot, Bobath).
- ✓ Perceptual training.
- ✓ Sensoristimulation.
- ✓ Facilitation techniques.

Ambulation Training

- ✓ Gait training (crutch, cane, walker).
- ✓ Gait training (level, incline, stair climbing).
- ✓ Gait training (parallel bars).

Miscellaneous

- ✓ Aseptic procedures (sterile).
- ✓ Functional training (activities of daily living) including:
  - → Self-care training.
  - → Transfers.
  - → Wheelchair independence.
- ✓ Orthotic training.
- ✓ Positioning.
- ✓ Posture training.
- ✓ Preprosthetic training includes the following:
  - → Desensitization.
  - → Strengthening.
  - → Wrapping.
- ✓ Prosthetic training.
- ✓ Postural drainage.
- ✓ Home program.

Appendix 9
Prior Authorization Request Form (PA/RF) for Physical Therapy Services Sample

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 111

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Billing
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 87654300

10 DX: PRIMARY: 436 - CVA

11 DX: SECONDARY: 437.0 - Cerebral atherosclerosis

12 START DATE OF SOI: N/A

13 FIRST DATE RX: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 OR	20 CHARGES
97116	PT	4	1	Gait training/transferring 15 min x 3/wk x 11 wk	33	XXX.XX
97110	PT	4	1	Strengthening exercises 15 mins / 3 wk x 11 wk	33	XXX.XX
97032	PT	4	1	E Stim	20	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY
DATE

24 _____
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE _____ EXPIRATION DATE _____ PROCEDURE(S) AUTHORIZED _____ QUANTITY AUTHORIZED _____

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

_____ DATE

_____ CONSULTANT/ANALYST SIGNATURE

Appendix 9a
Prior Authorization Request Form (PA/RF) Completion Instructions (Physical Therapy)

See Appendix 10a of this handbook for Spell of Illness PA/RF instructions.

Element 1 - Processing Type
Enter processing type 111, Physical Therapy.

Element 2 - Recipient's Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 3 - Recipient's Name
Enter the recipient's last name, first name, and middle initial from the recipient's current identification card.

Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41) from the recipient's current identification card.

Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

Element 7 - Billing Provider's Name, Address, and Zip Code
Enter the billing provider's name and complete address (street, city, state, and zip code). *Do not enter any other information in this element since it also serves as a return mailing label.*

Element 8 - Billing Provider's Telephone Number
Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 - Billing Provider's Medicaid Provider Number
Enter the billing provider's eight-digit provider number.

Element 10 - Recipient's Primary Diagnosis
Enter the appropriate *International Classification of Disease, 9th Edition, Clinical Modification* (ICD-9-CM) diagnosis *code and description most* relevant to the service/procedure requested.

Element 11 - Recipient's Secondary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description* additionally descriptive of the recipient's clinical condition.

Element 12 - Start Date of Spell of Illness
Do not complete this element *unless* requesting a therapy (PT, OT, speech) spell of illness. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 13 - First Date of Treatment
Do not complete this element *unless* requesting a therapy (PT,OT, speech) spell of illness. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 14 - Procedure Code(s)
Enter the appropriate HCPCS procedure code as described in the plan of care in this element.

Element 15 - Modifier
Enter the "PT" modifier appropriate for each procedure code.

Element 16 - Place of Service
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
0	Other
3	Office
4	Home
7	Nursing Facility
8	Skilled Nursing Facility

Element 17 - Type of Service
Enter the appropriate type of service code for each service/procedure/item requested. *Do not complete* this element if requesting a therapy (physical therapy) spell of illness.

Numeric	Description
1	Medical
9	Rehabilitation Agency

Element 18 - Description of Service
Enter a written description corresponding to the appropriate HCPCS procedure code for each service/procedure requested.

Element 19 - Quantity of Service Requested
Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure requested.

Element 20 - Charges
Enter your usual and customary charge for each service/procedure requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure requested. Enter that total amount in this element.

> *Note:* The charges indicated on the *request form* must reflect the provider's usual and customary charge for the procedure requested. Providers are paid for authorized services according to the Department of Health and Family Services' *Terms of Reimbursement.*

Element 21 - Total Charge
Enter the anticipated total charge for this request.

Element 22 - Billing Claim Payment Clarification Statement
An approved authorization does not guarantee payment. Payment is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment is not be made for services initiated prior to approval or after authorization expiration. Payment is in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid-contracted managed care program at the time a prior authorized service is provided, Medicaid payment is allowed only if the service is not covered by the managed care program.

Element 23 - Date
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

Element 24 - Requesting Provider's Signature
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

Do not enter any information below the signature of the requesting provider - This space is used by Medicaid consultant(s) and analyst(s).

Appendix 10
Prior Authorization Therapy Attachment (PA/TA) Sample
(Physical Therapy)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/TA

THERAPY ATTACHMENT
(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF
   (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

① LAST NAME	② FIRST NAME	③ MIDDLE INITIAL	④ MEDICAL ASSISTANCE ID NUMBER	⑤ AGE
Recipient	Im	A	1234567890	69

PROVIDER INFORMATION

⑥ THERAPIST'S NAME AND CREDENTIALS	⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ THERAPIST'S TELEPHONE NUMBER
I.M. Performing	12345600	(XXX) XXX - XXXX

⑨ I.M. Referring/Prescribing
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. Requesting: ☒ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

B. Total time per day requested: 15 minutes
Total Sessions per week requested: 3
Total number of weeks requested: 11

C. Provide a description of the recipient's diagnosis and problems including date of onset.

R CVA

Hysterectomy 2° adenocarcinoma - 1992
Adult onset diabetes - several years duration
CHF - several years duration

D. Brief Pertinent History:

Patient was admitted 3/12/95 after hospitalization for acute CVA 2/27/95.

Hospitalized from 5/6/95 to 5/12/95 for pneumonia. Has been medically stable and alert since return on 5/12/95.

E. Therapy History:

	Location	Date	Problem Treated
PT	Hospital	3/1/95 to 3/11/95	CVA
	Nursing Home	3/13/95 to 5/6/95	CVA
		5/13/95 to present	

OT

N/A

SP

N/A

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation)

	3/12/95	5/12/95
Orientation	A & O x 3	A & O x 3
ROM	WFL except L shldr flex= 0-140° Abd.= 0-140° Lat. Rot.= 0-45° L knee ext. = 10-100°	WFL except L shldr flex= 0-110° Abd.= 0-110° Lat. Rot.= 0-45° L knee ext.= 15°-95° L ankle dorsi flex= -10°
Strength	R extremities in GOOD range L UE flaccid L LE hip & knee POOR range	R U & L E F+ to GOOD- L UE non-func C moderate Flexor spasticity present L LE hip & knee FAIR L ankle TRACE
Transfers	Stnding pivot requires max of 2	Standing pivot mod of 1
Elevations	Supine ↔ sit max of 1 Sit ↔ stand max of 2	Supine ↔ sit min of 1 Sit ↔ stand mod of 1
Ambulation	Non-ambulation	In parallel bars of 10'x2 with max assist of 1, able to advance L LE indep. 70% of time
Sitting Balance	Unsupported requires max of 1	Unsupported indep. x 60 sec if unchallenged

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

6/18/92

Orientation	0
ROM	L knee ROM= 5-100° L ankle dorsi flex= 0°
Strength	R UE & RLE - GOOD →G+ L UE-Zero, L LE - hip & knee - FAIR- ankle-POOR range, AFO obtained 5/15/95 to assist in transfer/gait.
Transfers	Standing pivot with guarded to min of 1 in PT & on unit
Elevations	Supine ↔ sit ↔ stand with guarded to min of 1.
Ambulation	10'x2 with minimum of 1 and hemi-walker. Amb. 1 x1/day on nursing unit.
Sitting Balance	Able to accept moderate challenges and maintain sitting balance.

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

	GOALS	PROCEDURES
1.	Amb. with cane With SBA of 1, 120'x2	Gait training Therapeutic exercise
2.	Indep. mobility, transfers	Therapeutic exercise
3.	Left knee ROM - Normal	Therapeutic exercise
4.	Left ankle strength POOR^{+} →FAIR	

Long Term Goals - Independent mobility, LLE ROM WNL, Return to semi-independent living

★ Code 97032 requested as possible adjunct, to therapeutic exercise.

I. Rehabilitation Potential:

Very good potential to meet goals. Patient has progressed steadily with short period of decline in May only.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J.

Signature of Prescribing Physician (A copy of the Physician's order sheet is acceptable)	Signature of Therapist Providing Treatment
MM/DD/YY Date	MM/DD/YY Date

Appendix 10a
Prior Authorization Therapy Attachment (PA/TA) Completion Instructions (Physical Therapy)

Do not use this attachment to request a spell of illness. Use the Prior Authorization Spell of Illness Attachment (PA/SOIA).

Timely determination of prior authorization is significantly increased by submitting thorough documentation when requesting prior authorization to extend treatment beyond 35 treatment days for the same spell of illness. Carefully complete the Prior Authorization Therapy Attachment (PA/TA) form, attach it to the Prior Authorization Request Form (PA/RF), and submit to the following address:

EDS
Attn: Prior Authorization, Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding the completion of the PA/RF and/or PA/TA may be directed to the fiscal agent's Policy/Billing Correspondence. Telephone numbers are in Appendix 2 of Part A, the all-provider handbook.

Recipient Information:

Element 1 - Recipient's Last Name
Enter the recipient's last name from the recipient's current identification card.

Element 2 - Recipient's First Name
Enter the recipient's first name from the recipient's current identification card.

Element 3 - Recipient's Middle Initial
Enter the recipient's middle initial from the recipient's current identification card.

Element 4 - Recipient's Medicaid Identification Number
Enter the recipient's ten-digit identification number from the recipient's current identification card.

Element 5 - Recipient's Numerical Age
Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

Provider Information:

Element 6 - Therapist's Name and Credentials
Enter the name and credentials of the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter the name of the supervising therapist.

Element 7 - Therapist's Medicaid Provider Number
Enter the eight-digit provider number of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 8 - Therapist's Telephone Number
Enter the telephone number, including area code, of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter the telephone number of the supervising therapist.

Element 9 - Referring/Prescribing Physician's Name
Enter the name of the physician referring/prescribing evaluation/ treatment.

The remaining portion of this attachment is to be used to document the justification for the requested service.

1. Complete elements A through J.

2. Element E - Provide a brief past history based on available information.

   Element F - Provide the evaluation results (you may attach the therapy evaluation to comply with this requirement).

   Element I - Provide the recipient's perceived potential to meet therapy goals.

3. Read the 'Prior Authorization Statement' before signing and dating the attachment.

4. The attachment must be signed and dated by the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, the supervising therapist must sign the attachment.

   The request must be accompanied by a physician's signature (a copy of the physician's order sheet dated within 90 days of its receipt by the fiscal agent indicating the physician's signature is acceptable). Also, the request will be returned to the provider if the required documentation is missing from the request form.

5. Refer to Section III- E of this handbook for additional attachments that may be required.

Appendix 11
Prior Authorization Request Form (PA/RF)
Spell of Illness Sample
(Physical Therapy)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 114

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Billing
1 W. Williams
Anytown, WI 55555

8 BILLING PROVIDER NO.: 87654300

10 DX: PRIMARY: 436 - CVA

11 DX: SECONDARY: 437.0 - Cerebral atherosclerosis

12 START DATE OF SOI: MM/DD/YY

13 FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 OR	20 CHARGES
		8		Physical Therapy Spell of Illness	35	XX.XX
97116	PT	4	1	Gait Training		
97010	PT	4	1	Hot Packs		
				TOTAL CHARGE		21 XX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE) 24 _____ (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED — GRANT DATE _____ EXPIRATION DATE _____ PROCEDURE(S) AUTHORIZED _____ QUANTITY AUTHORIZED _____

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

_____ DATE

_____ CONSULTANT/ANALYST SIGNATURE

Appendix 11a
Prior Authorization Request Form (PA/RF)
Spell of Illness Completion Instructions
(Physical Therapy)

Element 1 - Processing Type
Enter processing type 114, Physical Therapy (spell of illness only).

Element 2 - Recipient's Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 3 - Recipient's Name
Enter the recipient's last name, followed by first name and middle initial, from the recipient's current identification card.

Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41) from the recipient's current identification card.

Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

Element 7 - Billing Provider's Name, Address, and Zip Code
Enter the billing provider's name and complete address (street, city, state, and zip code). *Do not enter any other information in this element since it also serves as a return mailing label.*

Element 8 - Billing Provider's Telephone Number
Enter the *billing provider's* telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 - Billing Provider's Medicaid Provider Number
Enter the billing provider's eight-digit provider number.

Element 10 - Recipient's Primary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description most* relevant to the service/procedure requested.

Element 11 - Recipient's Secondary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description* additionally descriptive of the recipient's clinical condition.

Element 12 - Start Date of Spell of Illness
Enter the date of onset for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 13 - First Date of Treatment
Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 14 - Procedure Code(s)
Enter the procedure code as described in the plan of care.

Element 15 - Modifier
Enter the "PT" modifier appropriate for each procedure code.

Element 16 - Place of Service
Enter the appropriate place of service code.

Numeric	Description
0	Other
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

Element 17 - Type of Service
Enter the appropriate type of service code for each service/procedure/item requested. This includes therapy services and therapy spells of illness (Physical Therapy).

Numeric	Description
1	Medical
9	Rehabilitation Agency

Element 18 - Description of Service
Enter the appropriate procedure code description.

Element 19 - Quantity of Service Requested
Enter the number of treatment days requested, per procedure code.

Element 20 - Charges (leave this element blank)

Element 21 - Total Charge (leave this element blank)

Element 22 - Billing Claim Payment Clarification Statement
Please read the "Billing Claim Payment Clarification Statement" printed on the request before dating and signing the prior authorization request form.

> "An approved authorization does not guarantee payment. Payment is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Payment is in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid-contracted managed care program at the time a prior authorized service is provided, Medicaid payment is allowed only if the service is not covered by the managed care program."

Element 23 - Date
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

Element 24 - Requesting Provider's Signature
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

Do not enter any information below the signature of the requesting provider - This space is reserved for Medicaid consultant(s) and analyst(s).

Appendix 12
Prior Authorization Spell of Illness Attachment (PA/SOIA) Sample
(Physical Therapy)

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT
(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

① LAST NAME	② FIRST NAME	③ MIDDLE INITIAL	④ MEDICAL ASSISTANCE ID NUMBER	⑤ AGE
Recipient	Im	A.	1234567890	29

PROVIDER INFORMATION

⑥ THERAPIST'S NAME AND CREDENTIALS	⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ THERAPIST'S TELEPHONE NUMBER
I.M. Performing PT	12345600	(XXX) XXX - XXXX

⑨ I.M. Referring MD
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. ☒ Physical Therapy SOI ☐ Occupational Therapy SOI ☐ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems. Indicate the functional regression which has occurred and the potential to reachieve the previous skill level.

PT fix'd pelvis on 6/18/94. Had been amb c cane c guarded to min assist of 1 on the unit. Was transferring c standby assist only. No % pain. Therapy initiated 6/25/94. PT requires max assist of 1 c walker to amb. Transfers require max of 1. % pain is constant c any movement. Expect PT to return to previous amb/transfer status and to be maintained by restorative nursing.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.

D. What is the anticipated end date of the spell of illness?

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. _____ MM/DD/YY
Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) — Date

G. _____ MM/DD/YY
Signature of Therapist Providing Evaluation/Treatment — Date

Appendix 12a
Prior Authorization Spell of Illness Attachment (PA/SOIA)
Completion Instructions
(Physical Therapy)

Do not use this attachment to request prior authorization to extend treatment beyond 35 treatment days for the same spell of illness. Use the Prior Authorization Therapy Attachment (PA/TA).

Timely determination of prior authorization is significantly increased by submitting thorough documentation when requesting prior authorization for a spell of illness. Carefully complete the Prior Authorization Spell of Illness Attachment (PA/SOIA) form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Attn: Prior Authorization, Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding the completion of the PA/RF and/or PA/SOIA may be directed to the fiscal agent's Policy/Billing Correspondence Unit. Telephone numbers are in Appendix 2 of Part A, the all-provider handbook.

Recipient Information:

Element 1 - Recipient's Last Name
Enter the recipient's last name from the recipient's current identification card.

Element 2 - Recipient's First Name
Enter the recipient's first name from the recipient's current identification card.

Element 3 - Recipient's Middle Initial
Enter the recipient's middle initial from the recipient's current identification card.

Element 4 - Recipient's Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 5 - Recipient's Age
Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

Provider Information:

Element 6 - Therapist's Name and Credentials
Enter the name and credentials of the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter his/her name and credentials, also enter the name of the supervising therapist.

Element 7 - Therapist's Medicaid Provider Number
Enter the eight-digit provider number of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter his/her provider number and the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 8 - Therapist's Telephone Number
Enter the telephone number, including area code, of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter his/her telephone number and the telephone number of the supervising therapist.

Element 9 - Referring/Prescribing Physician's Name

Enter the name of the physician referring/prescribing evaluation/treatment.

Part A

Enter an "X" in the appropriate box to indicate a physical, occupational, or speech therapy spell of illness request.

Part B

Enter a description of the recipient's diagnosis and problems. Indicate what functional regression has occurred and what the potential is to reachieve the previous skill.

Part C

Attach a copy of the recipient's Therapy Plan of Care, including a current dated evaluation, to the Spell of Illness attachment before submitting the spell of illness request.

Part D

Enter the anticipated end date of the spell of illness in the space provided.

Part E

Attach the physician's dated signature on either the Therapy Plan of Care or copy of the physician's order sheet to this attachment.

Read the 'Prior Authorization Statement' before signing and dating the attachment.

Part F

The signature of the prescribing physician and the date must appear in the space provided. (A signed copy of the physician's order sheet is acceptable.)

Part G

The dated signature of the therapist providing evaluation/treatment must appear in the space provided.

Appendix 13
Spell of Illness Guide

Injury/Illness	Submit PA/Spell of Illness Forms?	Treatment Days	Submit PA/TA Form?
First time in treatment (femoral fracture)	no	30 days	n/a
Second time in treatment (mild CVA-ability to reachieve ADLS is possible)	yes	65 days	Submit the PA/RF and PA/TA forms to the fiscal agent within two weeks before spell of illness ends.
Third time in treatment (decubitus ulcer)	This diagnosis never qualifies for a spell of illness.	100 days	Submit PA/RF and PA/TA forms to the fiscal agent within two weeks of evaluation.
Fourth time in treatment (humeral fracture)	yes	26 days	n/a
Fifth time in treatment (severe CVA-ability to reachieve ADLS is questionable)	Does not qualify as spell of illness	14 days	Submit PA/RF and PA/TA forms to the fiscal agent within two weeks of evaluation.

Appendix 14
Helpful Hints for Working with Wisconsin Medicaid

The following tips are a compilation of information collected from providers participating in the Wisconsin Occupational Therapy Association (WOTA) Medicaid Committee, and information presented at symposiums sponsored by the committee. The information has been edited and updated by the Bureau of Health Care Financing (BHCF) therapy consultants. These tips are meant as guidelines to improve your documentation and to assist you in completing Medicaid forms accurately and completely.

Prior Authorizations

✓ If information regarding the recipient's previous therapy history is unavailable, submit a prior authorization request.

✓ Fill out all forms completely and accurately. Each time a prior authorization request is sent back to the provider for more information, there is a delay in services.

✓ A prior authorization request must be sent to the fiscal agent at least two weeks, but no more than three weeks, before the expiration date of the existing prior authorization.

✓ Check the recipient's 10-digit identification number before mailing the request to the fiscal agent.

✓ Please list onset dates for all diagnoses. If specific dates are not available, enter an approximate date based on the best information available and explain the circumstances.

✓ Count weeks and sessions accurately to ensure authorizations for sufficient sessions. Count from the requested start date. Remember, the consultant cannot grant more than you request.

✓ The initial request for prior authorization can be backdated two weeks to the date the request is initially received by the fiscal agent. Continuous therapy may not be backdated. To request backdating, write "Please backdate to *(date)* because *(reason)*" on the PA/RF.

✓ In the event that your initial prior authorization request is returned for clarification, provide written clarification and attach your response to the original PA/RF and return this PA/RF with all attachments to the fiscal agent. The original PA/RF was stamped with the ICN date when it was first received by the fiscal agent. The prior authorization may be backdated to the ICN date, only if you specifically request this.

✓ In cases when you have difficulty getting a doctor's signature on the initial plan of care which has caused your prior authorization to be late, attach a memo of explanation which the fiscal agent may consider in dating your authorization.

✓ The codes at the bottom of the PA/RF near the consultant's signature are common messages regarding action or recommendations by the consultant which have been assigned a computer code.

✓ Remember to use black ink. This makes the photocopies easier to read.

✓ A plan of care must be formulated from a valid data base (evaluation). Prior authorizations are not approved if the evaluation results are not included.

✓ If there is an interruption in services and you have excess sessions to use, you may change frequency if appropriate for the recipient, as long as you don't exceed the number of sessions granted or the end date. Include an explanation of the circumstances on your next prior authorization.

Hints (continued)

- ✓ You may change your treatment plan during a prior authorization; however, be sure to include the dates and rationale on your next prior authorization request.
- ✓ Please write legibly, and ensure legibility of copies. If the consultant cannot read your documents, they may get sent back.
- ✓ Only use basic or common abbreviations.
- ✓ If your prior authorization is returned "denied," you have the right to call the consultant to discuss the decision. If the consultant agrees to change the decision, submit a new prior authorization request with the additional documentation required by consultant. Attach a copy of the denied prior authorization.
- ✓ If the consultant stands by the denial, the recipient has the right to appeal through the fair hearing process.
- ✓ Prior authorizations returned to the provider for more information must be returned to the fiscal agent within a two-week period.
- ✓ If the reviewing consultant writes "D/C at end of PA" on the returned PA/RF, and you feel the recipient would benefit from further treatment, write another prior authorization clarifying medical reason for additional treatment.
- ✓ Make sure your goals are objective, measurable, and functional.
- ✓ Record all progress, no matter how small.
- ✓ Include function and safety issues when appropriate.
- ✓ Try to use standardized evaluations whenever possible.
- ✓ Include norms with test scores.
- ✓ Include specific carryover recommendations for patient, facility, staff, and/or family. After six months, carryover must be demonstrated to grant continued treatment.
- ✓ Highlight pertinent data.
- ✓ Suggested formats:
  - → List your data in columns - past and present.
  - → Use areas, problems resolved, problems improved, problems unresolved, carryover.
- ✓ Maintenance is a covered treatment, as long as *skilled* therapy services are required.
- ✓ "Medical Necessity" is defined in HSS 101.03 (96m), Wis. Admin. Code.

Spells of Illness (SOIs)

- ✓ New diagnoses or exacerbations that result in a functional regression generally qualify as a spell of illness.
- ✓ Be sure to include a copy of the current evaluation, a comparison to prior abilities, and an estimate of the patient's ability to return to prior level of function.

Hints (continued)

- ✓ Remember, any health insurance (including Medicare) paid sessions (excluding inpatient hospital days) *count* toward the original 35 days of treatment for a spell of illness.

- ✓ You may submit a copy of the monthly signed doctor's orders in lieu of a signature on the PA/TA, as long as the order indicates what treatment the doctor is prescribing.

General Information

- ✓ BID treatment counts as one session, so long as it does not exceed 90 minutes per day.

- ✓ Daily treatment time must not exceed the limitation of 90 minutes per treatment day. However, under extraordinary circumstances you may request more time. After you receive payment for the 90 minutes, submit an adjustment form with the specific reason for exceeding the 90 minute limitation documented on the adjustment form.

- ✓ Make sure treatment and documentation by a PTA are in accordance with the Wisconsin Administrative Code laws and practice standards.

- ✓ Splinting treatment including evaluation and associated expenses are billed separately from other treatment sessions as durable medical equipment. Refer to the DME Index for correct procedure codes.

Appendix 15
Medicaid Declaration of Supervision for Non-Billing Providers

The following providers are issued non-billing provider numbers (*cannot be used independently* to bill Wisconsin Medicaid), must be under professional supervision to be Medicaid-certified providers, and *must* complete this form:

Alcohol and Other Drug Abuse Counselor (31/048)
Psychiatric Nurse (31/049)
Master's Level Psychotherapist (31/078)
Physical Therapy Assistant (34/077)
Occupational Therapy Assistant (35/114)
Speech Pathologist, BA Level (78/091)
Physician Assistant (88/079)

Return to: EDS, Attn: Provider Maintenance, 6406 Bridge Road, Madison, WI 53784-0006

Note: If supervisor and address change, refer to Appendices 34 and 34a of Part A, the all-provider handbook.

To be completed by the applicant who is a Non-Billing Provider or Current Non-Billing Provider who has a Change in Work Address or Supervisor (always required):

Name and Credentials:_____ Phone:(_____)_____

Work Mailing Address:_____

Since Medicaid payments cannot be made payable to me, I, _____, hereby direct the fiscal agent for Wisconsin Medicaid, EDS, to make checks payable to (clinic or supervisor's name for providers other than mental health) _____ for all claims payments for services performed by me under Wisconsin Medicaid. I understand that this payment arrangement shall continue in effect until the fiscal agent receives a new Declaration of Supervision form from me. When my supervisor, employer, or work address changes, I will immediately send this form completed again to the fiscal agent.

Date	Signature of Non-Billing Provider	Medicaid Provider Number
_____	_____	_____

To be completed by the Supervisor (always required):

Name:_____ Employer IRS #_____ Phone:(_____)_____

Address:_____

I, _____, am supervising the work of _____.
The effective starting date of my supervision was _____. I hereby acknowledge and agree to the above payment arrangement. I understand that if my name is indicated in the above section, Wisconsin Medicaid checks for services provided by the above provider will be payable to me directly and will be reported under the IRS# written here. If I discontinue supervision of the above, I understand that I must send notice to the fiscal agent at the above address.

Date	Signature of Supervisor	Medicaid Provider Number
_____	_____	_____

To be completed by the Clinic Manager (required for mental health non-billers only):

Note: Outpatient mental health/AODA clinics who employ non-billing providers *must* be certified by the Division of Community Services *and* Wisconsin Medicaid. Staff of non-51.42 board clinics providing Medicaid services *must* be individually certified.

On behalf of (Clinic Name) _____, (Medicaid Provider Number) _____
I hereby acknowledge and agree to the above payment arrangement. I understand that Wisconsin Medicaid checks for services provided by the above non-billing provider will be payable to the clinic and reported under this IRS#.

Date	Name and Signature of Clinic Manager	Employer IRS #
_____	_____	_____

Clinic Address:_____ Phone:(_____)_____

Appendix 16
Paperless Claim Request Form
Wisconsin Medicaid Electronic Information Request Form

Wisconsin Medicaid offers many different methods for submitting Medicaid claims electronically. All of this information is available for downloading from the EDS bulletin board system (EDS-EPIX). By downloading, you are able to obtain this information within minutes at your convenience. Please refer to the back of this page for the "Quick Guide to Obtaining Medicaid Electronic Claim Information" to assist you with the downloading process.

❑ **ECS (Electronic Claim Submission):** EDS supplies free software that runs on a stand-alone IBM compatible computer and uses a Hayes compatible modem. Electronic record layouts are also available to create your own data files containing Medicaid claim information.

❑ 3 1/2" diskette ❑ 5 1/4" diskette

❑ **3780 Protocol:** 3780 protocol is an IBM communication protocol that enables mini or mainframe computers to send claim data files to EDS.

❑ **Magnetic Tape:** Providers with the capability to create claim information on tape can submit those tapes to EDS. EDS also provides Remittance Advice information on magnetic tape.

❑ **MicroECS:** MicroECS allows providers to send data files to EDS using most basic telecommunication packages at a line speed up to 9600 bps.

❑ **Reformatter:** The Reformatter is software designed for EDS that enables providers to enjoy the benefits of electronic billing without making costly changes to their existing billing system. Instead of printing claims on paper, claims are printed to a data file on a personal computer and transmitted to EDS. EDS reformats the data into the required electronic record format and brings the claims into the Medicaid processing system.

❑ Please send me additional information on EDS' bulletin board system (EDS-EPIX).

If you are unable to download and would like information on electronic claim submission, please check off the above method(s) you are interested in and complete the following:

Name: _____ Provider Number: _____

Address: _____ Type of Service: _____

_____ Contact Person: _____

_____ Phone Number: _____

Please return to: EDS
6406 Bridge Rd.
Madison, WI 53784-0009

EDS-EPIX (V 1.1) Quick Guide to Obtaining Wisconsin Medicaid Electronic Information

This is a quick guide to retrieving and installing EDS' Electronic Claim Submission software using *EDS-EPIX.*

1. If you wish to obtain EDS Software, create a subdirectory on your hard drive for your Electronic Claim Submission software called "EDS". At the DOS command prompt, type:

   C: <Enter>
   CD\ <Enter>
   MD EDS <Enter>

2. Set up your communication software to dial *EDS-EPIX.* You may need to program your software to dial with the following settings:

Phone Number:	(608) 221-8824	**Stop Bits:**	1
Baud Rate:	14,400 (maximum)	**Duplex:**	Full
Parity:	None	**Protocol:**	XMODEM (recommended)
Data Bits:	8	**Terminal Emulation:**	ANSI

3. Dial into *EDS-EPIX.* When you go through this initial logon, we recommend you select Xmodem/CRC as your default protocol.

4. Select option "F" (File Directories) from the main menu, and view the "ECS Software and Manuals for New Users" or the "Record Layout and Manual Updates" directory. Choose the name of the file you need to download. If you need help deciding which file you need, go back to the main menu and view Bulletin #2 or 3 for more information. When you have chosen a file, write down the file name (you will need it to download).

5. Select option "D" (Download a File) from the main menu, and type the file name you chose in step 4. Next, follow the download instructions in the user manual for your communications software package. This involves telling your communications software package that you wish to "Receive a File", choosing a transfer protocol, and specifying the name and directory path of the file. If you fail to specify the directory path with the file name, the file will be downloaded into the default download directory for your communications software.

6. When you have downloaded your file, select "G" (Goodbye) to end your *EDS-EPIX* session, quit your communication software, and return to DOS.

7. Go to the subdirectory you specified in your path and look for your download file. It must be listed when you list the directory.

8. If the download file is in the directory, you will need to decompress the file. At the DOS command prompt, type the name of the download file without the ".EXE" extension. For example: for dental software, at the DOS command prompt, type:

   DENTAL <Enter>

9. This will extract your software and manual(s).

10. The files ending in .DOC are your manuals. This manual is an ASCII DOS text file. To print this document, use the DOS Print command:

    PRINT *FILENAME*.DOC <Enter>

    The document will be printed on the print device you specify.

Appendix 17
Avoiding and Resolving Common Claim Denials

EOB code	Message/Resource/Related Claim Form Element
281	Recipient Medicaid identification number incorrect Medicaid identification card or other eligibility resource → Part A, Section I-C Element 1a
29	Recipient's last name does not match number Medicaid identification card or other eligibility resource → Part A, Section I-C Element 2
614	Recipient's first name does not match number Medicaid identification card or other eligibility resource → Part A, Section I-C Element 2
278	Medicaid files show recipient has other health insurance Part A, Appendix 18 Element 9 (if paid also use element 29)
10	Recipient eligible for Medicare; bill Medicare first Part A, Appendix 17 Medicare-allowed charges → Attach Medicare EOMB Medicare Denied charges → Element 11 (use M-code and do not attach EOMB)
433	Physical therapy limited to 35 treatment days without prior authorization Part P, Section III Element 23
172	Recipient not eligible for date of service billed Medicaid identification card or other eligibility resource → Part A, Section I-C Element 24a
171	Claim/Adjustment received after 12 months from date of service Part A, Section 9-F Element 24a
177	Place of service invalid or not payable Part P, Appendix 4 Element 24b
180	Procedure not payable for type of service or invalid type of service code submitted Part P, Appendix 3 Element 24c
388	Procedure code is incorrect and/or the type of service is not correct for the procedure Part P, Appendix 3 Element 24c and/or 24d
183	Provider not authorized to perform procedure code and/or type of service code Element 24k
175	Performing Provider number is missing/invalid for this procedure Element 24k

EOB code	Message/Resource/Related Claim Form Element
424	Billing provider name/number missing, mismatched, or invalid Element 33
100	Claim previously/partially paid on (claim number and R & S date) Part A, Appendix 27 Adjustment Request Form
399	Date of service must fall between the prior authorization grant date and expiration date Part A, Section III-B

Note: ✓ HCFA 1500 claim form completion instructions are in Appendix 1b of this handbook.
✓ Request an amendment to authorized prior authorization grant and/or expiration dates to conform to the actual dates of service rendered.

Remittance and Status (R&S) Report with EOB Codes Example

This is a partial R&S Report. Actual R&S Reports contain more information. The EOB code is circled in this example.

REMITTANCE AND STATUS REPORT

EDS - Fiscal Agent For the Wisconsin Medical Assistance Program
6406 Bridge Road
Madison, WI. 53784
Voice Response 800/947-3544 608/221-4247
Policy/Billing 800/947-9627 608/221-9883
Eligibility 608/221-9254

PROVIDER NUMBER 87654321 REPORT SEQ NUMBER 2 DATE 07/06/92 PAGE 2

PATIENT NAME/ID NUMBER / SERVICE DATES FROM | TO	UNITS	PERF PROV ID NUMBER	MEDICAL RECORD NO / DAYS QTY	T OF S	PROC/ACCOM/DRUG CODE/MOD NO	ACCOUNTING NO / CLAIM NUMBER / PROCEDURE/ACCOMMODATION/DRUG DESCRIPTION	TOTAL BILLED	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES
ADJUSTMENT TO CLAIMS												
RECIPIENT IM/1234567890 112590 112590			2		1 90040	399892XXXXXXXXX BRIEF SERVICE	22 00	00	00	00	00	281 281 743 80
1 123 THIS IS AN ADJUSTMENT TO PREVIOUS CLAIM 209890XXXXXXXXX 1234567890						209890XXXXXXXXX	PAID ON 122690					
112590 112590			10		1 90040	CLAIM TOTAL	-2200 -2200	-1623 -1623	00 00	-100 -100	-1523 -1523	1 8
3 601 RECEIVABLE ESTABLISHED FOR A BALANCE OF $15.23 WHICH WILL BE WITHHELD FROM FUTURE PAYMENTS												
CLAIM TYPE SUB-TOTAL PAID CLAIM TOTALS			2 1				00 2200	1623 00	00 -104 28	000000 000000	-15 23 00	

Appendix 18
Blank HCFA 1500 Claim Form

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500